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2 HIF092.140

3 HEARING ON ``MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES:

4 SAVING MONEY, SAVING LIVES''

5 THURSDAY, APRIL 2, 2009

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The subcommittee met, pursuant to call, at 10:07 a.m.,

11 in Room 2123 of the Rayburn House Office Building, Hon. Frank

12 Pallone Jr. (chairman) presiding.

13 Members present: Representatives Pallone, Dingell,

14 Green, DeGette, Capps, Schakowsky, Baldwin, Matheson, Castor,

15 Sarbanes, Sutton, Braley, Deal, Shimkus, Shadegg, Pitts,

16 Burgess, Blackburn, Gingrey, and Barton (ex officio).

17 Staff present: Karen Nelson, Deputy Staff Director for

18 Health; Karen Lightfoot, Communications Director; Jack

Ebeler, Senior Advisor on Health Policy; Stephen Cha, Professional Staff Member; Tim Gronninger, Professional Staff Member; Purvee Kempf, Counsel, Anne Morris, Legislative Analyst; Virgil Miller, Legislative Assistant; Camille Sealy, Detailee; Miriam Edelman, Special Assistant; Lindsay Vidal, Special Assistant; Alvin Banks, Special Assistant; Allison Corr, Special Assistant; Brandon Clark, Minority Professional Staff Member; Marie Fishpaw, Minority Professional Staff Member; Clay Alspach, Minority Counsel; Melissa Bartlett, Minority Counsel; and Chad Grant, Minority Legislative Analyst.

Mr. {Pallone.} The meeting of the subcommittee is called to order.

Today we are having our final hearing in this series on marking healthcare work for American families, and today we will examine how to get more value out of our healthcare dollars by improving quality and lowering costs. Earlier this week the Department of Health and Human Services issued a report on rising healthcare costs and the impact these costs are having on American families, businesses, and the Federal Government. According to this report the U.S. spent $2.2 trillion on healthcare in 2007, or $7,421 per person, and this comes to 16.2 percent of the gross domestic product, which is nearly twice the average of other developed nations.

If healthcare costs continue to grow at the current rate, they will account for 25 percent of GDP in 2025, and 49 percent in 2082. Clearly, this level of healthcare spending is simply not sustainable. So we need to figure out to change the trajectory of healthcare costs. Bending the cost curve even the slightest degree will help mitigate further growth and generate significant savings to our healthcare system. The difficult part is figuring out how, and that is why we are here today.

Part of the problem is how we pay for healthcare

services. There is an old saying that you get what you pay for. In this country we pay for the quantity of healthcare services provided, not the quality of the service. So it should come as little surprise that as utilization rates increase, healthcare costs rise and quality suffers.

But this isn't the story across the board. There is a lot of variation in the delivery of healthcare throughout our Nation. In parts of the country certain healthcare services are seeing tremendous growth and utilization. Yet in other parts there are concerns that patients aren't receiving enough of recommended care. So we need to understand better what explains this variation and how it is impacting our healthcare system in terms of both cost and quality.

Significant work has been done in this area by researchers at Dartmouth, including Dr. Jonathan Skinner, who we will hear from today. I think it is also important to note that these problems are prevalent throughout the healthcare system. A lot of people like to point to public programs like Medicare and Medicaid and use them as a scapegoat for healthcare costs run amuck, but the challenges we face with costs and quality aren't endemic to just public programs. Private insurers and employers must also begin to rethink the way they pay for healthcare services. Changes to Medicare payment policies can help drive that change.

And finally, I want to mention that we will also be examining the role of transparency when it comes to the delivery and purchasing of healthcare services. This has been a priority for our Ranking Member, Mr. Deal. I agree that consumers have the right to know what they are paying for when they see a doctor or enter a hospital, but that right also extends to other areas such as purchasing healthcare coverage. I think we need to be cognizant that transparency, while certainly a good thing, does have its limits. It is not realistic to expect transparency to be a panacea to controlling healthcare costs. Some, if not most, patients simply won’t be in the position to use this information or shop around for the best healthcare.

I want to thank our witnesses for being here today. I am looking forward to your testimony.

[The prepared statement of Mr. Pallone follows:]

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Mr. {Pallone.} And I now recognize Mr. Deal for the purposes of his opening statement.

Mr. {Deal.} Thank you, Mr. Chairman. I want to thank you, and I want to thank the witnesses in both panels today for your appearance.

Certainly the first panel today will raise a number of issues facing Congress. Chronic care is consuming a larger share of healthcare spending, treatment remains uncoordinated and oftentimes duplicative as a result of fragmented care and escalating costs threaten the coverage of millions of American families.

I am particularly appreciative that the chairman is willing to hold a panel hearing today on the second panel relating to healthcare transparency. As most of you know, I am currently making final revisions to my legislation Healthcare Transparency Act of 2009, which seeks to address many of the issues stemming from the exorbitant cost of medical items and services. My legislation addresses a core problem in our healthcare delivery system, which affects millions of American families.

Medical bills remain the leading cause of personal bankruptcy in this country, and with these concrete hard facts in mind it bears asking why anybody would want to

inhibit more transparent fair price healthcare market, fair prices in the healthcare market.

I have some charts, and I am going to ask if someone would put those charts up while I make a few more statements. The first reaction of many people in Washington would be to create thousands of pages of new pricing regulations to help solve the problem. I want to make it clear that I believe the best solution would be to simply follow President Obama's call for increased transparency and require any healthcare provider receiving federal funding to publicly disclose the price they charge to uninsured, to under-insured, and other self-pay patients. Given the efficiency created in today's internet-based marketplace, particularly as the healthcare industry makes dramatic steps towards wide adoption of HIT and EMR technologies, the task would be simple and would empower millions of Americans with critical information about the cost of their healthcare.

Another equally important component of the proposal would be to require health insurance companies to provide more information to patients before services are rendered. As you know, there are a number of factors which affect reimbursements provided by insurers such as deductibles, co-pays, and co-insurance rates and whether or not the provider is established as an in-network or out-of-network provider.

And I think people should know before they receive the services exactly what those services are going to cost.

Now, the charts that you see here are pictures made by staff members on a trip to Tanzania, Africa, and they are in Tanzanian shillings, and one United States dollar equals approximately 1,300 Tanzanian shillings. Now, the brown chart there is taken at a community hospital in Tanzania, and it is in, the chart is located in the front of the reception area at the hospital. As you might be able to translate there, ultrasound there is the equivalent of costing four U.S. dollars. Now, that is a little deceiving because the GDP and the gross domestic product of Tanzania is very low.

The white chart is a list taken outside the outpatient ward at a community health clinic. Now, it seems a little bit surprising to me that in what we would definitely call a third-world country their people going to their health providers have the right to know what the cost of their services are going to be, and they are publicly posted. I challenge you to find very many comparable environments in the United States where these prices are posted for the public to know before they receive the services, and think that is a shame and something that should be addressed, and we hopefully in this healthcare reform that we will undertake will have the opportunity to do that. We shouldn’t criticize

third-world countries when they have greater transparency than we do.

So thank you, Mr. Chairman. I appreciate your indulgence, and thank you for having both of the panels here today.

I yield back.

[The prepared statement of Mr. Deal follows:]

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Mr. {Pallone.} Thank you, Mr. Deal. Our Chairman Emeritus, Mr. Dingell.

Mr. {Dingell.} Thank you, Mr. Chairman, and I commend you for holding today's hearing.

In the healthcare reform debate which we are now engaged everybody can agree on at least two things; we must reduce the cost of our healthcare system so that it doesn't bankrupt our families and businesses and even government at all levels, and we must increase the quality of care so that we can get a better value for our dollar. This means a way must be found to see to it that we can control these costs and reduce the acceleration in growth of the costs that is moving forward.

The cost of our healthcare system is an unsustainable path, and we must now act to bend the cost curve before it is too late. We have created a system that makes money by running more tests, doing more surgeries, prescribing more drugs, even if the data doesn't back up the particular course of treatment, and of course, it involves buying large amounts of enormously expensive equipment as essentially a business promotion device.

One of our primary goals in drafting healthcare reform legislation will be to provide ways to incentive value of

care over volume of care. We must reform our healthcare system in a way that rewards providers for quality healthcare, reduces the number of hospital re-admissions, incentives primary care, and moves providers in the direction of creating integrated healthcare systems. And wellness must be a concern of ours as we go about this business.

We must recognize the need for consideration of evidence-based data in determining treatment plans in an effort to highlight treatments which are most cost effective. We should not be led to believe that only the most complex and most expensive procedures are the most effective. Most times this is not the case.

Studies show that standardizing certain procedures can save lives. For example, training staff on a simple matter like proper hand-washing procedures is still one of the best ways to prevent hospital-caused infections. Marking surgical sites on the patient’s body is another way to reduce medical errors, and this committee has had to address questions involving amputation of the wrong leg or removal of the wrong breast from patients in treatment errors of the most outrageous sort.

Pre and post-surgical checklists ensure that patients are receiving the best practices as developed by the medical community instead of invariability and quality of care are a

necessity.

Finally, we must create transparency in the healthcare marketplace. Transparency efforts must include a wide variety of information that allows patients, consumers to make well-informed decisions about insurance plans, services, and providers. A national health insurance exchange could be a very helpful event in this regard. Such an exchange which would offer a range of private insurance options in addition to a public insurance plan could simplify paperwork and make the difference among plans, including costs and services offered more transparent to the advantage of the patients and to the advantage of the system.

I look forward to hearing the testimony of our witnesses today about how we can improve the quality of our healthcare system, while also reducing the overall costs. Their incitement will be valuable in our meeting of the challenges ahead of us.

I thank you, and I yield back the balance of my time.

[The prepared statement of Mr. Dingell follows:]

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Mr. {Pallone.} Thank you, Chairman Dingell.

The gentleman from Illinois, Mr. Shimkus.

Mr. {Shimkus.} Thank you, Mr. Chairman, and one thing great about, especially this subcommittee is we have active members who are in the healthcare profession, doctors, we have got Lois, who is a nurse, and they really bring a great benefit of actually practitioners versus us who are just laypeople trying to figure out this very complex process. So I do--I have said it a couple of times, it is really a joy to be back on this subcommittee.

The--I think there is a new concern. Mr. Deal in his opening comment talked about, you know, government forcing transparency because we are in the process of being a big payer, and as you see with the TARP and Wall Street bailout and GM now with the Administration being able to tell the CEO to leave, I would expect more of that for anybody who gets government money of any size, shape, or form. I am not sure this is good for the country, but we are in a new era. And so if you are getting government money, expect government to start making decisions all the way down as to one of the bills we had on the Floor last night said that we may be able to determine the salary of the janitor in a corporation that accepted TARP money.

So figure out how that is going to affect healthcare in this for the Medicare and Medicaid, and I think you have to look at it, because as most people say, Medicare and Medicaid is a driving factor on health insurance reimbursements. So you can’t discard the underpayment by the government on these two provisions.

I am not sure how much time--I don’t know if I have gone that quickly, but if it is then I will yield back if--unless--if you hit the timer.

[The prepared statement of Mr. Shimkus follows:]

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Mr. {Pallone.} Thank you.

Mr. Green.

Mr. {Green.} Thank you, Mr. Chairman. I want to thank you for holding this hearing today on the health reform and access to care.

Currently there are 47 million uninsured in our country. Overall healthcare is consuming an ever-increasing amount of our resources. Healthcare estimates are now 16 percent of our GDP, and this rate could hit 20 percent by 2017, and as our chairman said, 25 percent later. Current estimates show that we are spending approximately $8,000 per person on healthcare per year. Unfortunately, we are paying more for the cost of healthcare but individuals are receiving less care for their money. Even though we have access to the most advanced technologies, fewer individuals seek treatment due to costs.

The current economic times highlight the fact that more individuals are uninsured simply because their companies cannot afford health insurance or the employees cannot afford the premium. Premiums are high because we have a reimbursement rate policy, including SGR, which does not accurately cover the cost of treatment. We also have a fee for services to reimburse physicians for volume, which often

rewards physicians who perform more procedures instead of focusing on better outcomes.

As we work to improve our healthcare system we hope we will finally address our payment system to encourage better health outcomes and treatment. I believe this is the root of our high-cost healthcare and unfortunately prevent individuals from having access to quality and affordable healthcare.

I want to thank our witnesses for appearing today, and I look forward to the testimony. I would also like to submit on behalf of my colleague, Representative Engel, written testimony for the record from the National Home Infusion Association, Mr. Chairman, and I yield back my time.

[The prepared statement of Mr. Green follows:]

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Mr. {Pallone.} So ordered without objection.

[The prepared statement of Mr. Engel follows:]

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Mr. {Pallone.} The gentleman from Pennsylvania, Mr. Pitts.

Mr. {Pitts.} Thank you, Mr. Chairman, for convening this hearing.

As we discuss healthcare reform, I can, I think we can all agree that patients should be more involved in their own care and treatment, but we will never drive down the out-of-control costs of healthcare if individuals do not take personal responsibility for their choices and behavior.

Too often, though, individuals' hands are tied. In many cases they do not have the one tool that might arguably be most important for driving prices down and quality up, to helping them make the very best decisions for their own lives and that is information.

What is the true cost of an emergency room visit or CT Scan? What about the same CT Scan in the country next door? Of the two hospitals nearest my home, which has a lower hospital-acquired infection rate or a lower error rate during surgery? If I am a self-paid patient, what am I paying compared to the person next to me who has private health insurance? None of us would accept this lack of transparency in other areas of our lives. I can pick up items in a supermarket, compare them using nutrition labels, all the

information I need to decide which item is healthiest is right there. We all know that knowledge is power, and that is why I commend Ranking Member Deal on his draft legislation, the Healthcare Transparency Act, designed to get consumers the information they need to make informed choices about their healthcare.

Mr. Chairman, I look forward to hearing the thoughts and testimony of the witnesses and thank you and yield back.

[The prepared statement of Mr. Pitts follows:]

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Mr. {Pallone.} Gentlewoman from Colorado, Ms. DeGette.

Ms. {DeGette.} Mr. Chairman, I think this is a very important hearing, and I will waive my opening statement in order to get more time on questioning.

[The prepared statement of Ms. DeGette follows:]

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Mr. {Pallone.} Gentleman from Georgia, Mr. Gingrey.

Mr. {Gingrey.} Thank you, Mr. Chairman. We have heard a lot of testimony over these past few weeks concerning the critical problems our healthcare system is currently experiencing.

Healthcare costs are rising faster than inflation and wages, and those costs create barriers to care for many, both insured, under-insured, uninsured, and of course, including lower-income families and those with chronic illness and the disabled.

We do need to fix healthcare so that everyone has the ability to see a quality doctor or to receive life-saving treatment. We also need to reform long-term care, pay providers based on quality of care they give patients and not just volume. We need the in defense of medicine through meaningful reform and support the creation of a complete system of electronic health records. I think this goes hand and glove with my colleague from Georgia, Ranking Member Deal, on his Healthcare Transparency Act.

This Congress is now on the verge of considering legislation that could fundamentally change the way we access healthcare in this country. Both sides of the debate want to make our current system of healthcare better. One side,

though, believes that reform should happen through direct government control. The other side, our side, believes that in order to make our system better, we need to fundamentally strengthen what works in healthcare and strengthen the doctor-patient relationship.

My hope is that this Congress works together in a bipartisan way to achieve meaningful reform that strengthens the doctor-patient relationship for every American and makes healthcare accessible and affordable for every American.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Mr. Gingrey follows:]

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Mr. {Pallone.} Thank you.

Subcommittee Vice Chair, Ms. Capps.

Ms. {Capps.} Thank you, Chairman Pallone, and welcome to all of our witnesses, and thank you for taking the time to be with us.

Today’s hearing is particularly important because it asks the question that is at the heart of our health reform debate. How do we improve the health of Americans while decreasing the skyrocketing costs of healthcare? The answer lies in how we define and reward healthcare delivery.

We must stop persisting with a complicated, cobbled-together system that really basically treats illnesses. Instead, we need to create a streamlined and comprehensive system which at its core strives to prevent illness and maintain health.

In order to make that change in healthcare we so desperately need, information-based, coordinated care that finds some way to reward prevention is important. This, I believe, is absolutely essential and a way to bring down costs as well.

So I look forward to hearing from our witnesses today, and I yield back.

[The prepared statement of Ms. Capps follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from Tennessee, Ms. Blackburn.

Ms. {Blackburn.} Thank you, Mr. Chairman. This has been an interesting, very interesting series of five hearings, and so you all are the ones that are going to finish this up for us today, and we welcome you all. I especially would like to welcome Mr. Smith, who is on the first panel and has been so diligent in helping me with healthcare issues in Tennessee, and I appreciate that. And Dr. Herzlinger, who has also been someone I have gone to for advice through the years.

Because in Tennessee we have had the system of TennCare, and as many of you know and have heard me say during this series of hearings, the mismanagement, very serious mismanagement issues that surrounded this program have caused some serious financial budgetary implications for our State. And I am one of those that as we have worked through this hearing it has reaffirmed to me how important it is that we have consumer empowerment, transparency, increased accountability, and the healthcare delivery systems. Without that we are going to see continued mismanagement of programs such as the TennCare Program.

Mr. Chairman, I will have to tell you the hearing title

was curious to me, saving money, saving lives. I wish we had said, saving lives while saving money and expecting better outcomes in healthcare delivery.

Welcome to you all, and I yield back.

[The prepared statement of Ms. Blackburn follows:]

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Mr. {Pallone.} Gentlewoman from Florida, Ms. Castor.

Ms. {Castor.} Thank you, Mr. Chairman, and welcome to all the witnesses.

You know, there is this great new technology that is available to members of Congress and others where we can hold telephone town hall meetings, and I did that Monday night, and the call goes out to everyone in your district, and they can just stay on the line or they can hang up if they are busy. We did it on the economy because folks are really struggling right now, and in my community where unemployment is over 10 percent and we have a very high foreclosure rate, I answered question after question on healthcare. The affordability, and we did this online poll where people can just press a button. Where do you get your healthcare, and we had one, we had about, we had over 4,000 people on the line, and it wasn’t very scientific but most receive their healthcare through their employer, employer-based health insurance, but every question was we just can’t afford it any longer. It is out of control.

The parent who had healthcare through the employer but their son was blocked, prevented because of a pre-existing condition from participating, left them out, just completely out in the lurch. The retired school teacher who still has

benefit through the school district is struggling with how to pay for prescription drugs, and that really hit home because that morning I was at a community health center with a pharmacy that had 340B pricing lowest, and I could not, I can’t rationalize the difference there.

So this is the front burner issue, and I look forward to your expert testimony and how we make healthcare more affordable for Americans. Thank you.

[The prepared statement of Ms. Castor follows:]

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Mr. {Pallone.} Thank you.

Gentleman from Texas, Mr. Burgess.

Mr. {Burgess.} I thank the chairman. We do have really a distinguished panel, two panels before us this morning. Of course, Dr. Goodman from down in North Texas, being a representative from Fort Worth, I won’t say Dallas, but nevertheless I am so glad to see you here, because I think your wisdom will be great. Dennis Smith, obviously has been a great help to me in crafting some of these things. Dr. Cassel, we have crossed paths numerous times before and certainly appreciate your testimony this morning. Dr. Herzlinger, Ron Bachman, appreciate you being here as well.

I support transparency and competition. I think our efforts must not drive behavior into the shadows but should truly try to better our care and empower the patient. If we want to move into a robust system of consumer-directed healthcare, clearly transparency is going to be a critical issue.

I had introduced legislation on this in the last Congress and perhaps will do so again. I realize it is a somewhat contentious task when you are dealing with all the stakeholders, but I do believe it is worth the effort.

Just a word on comparative effectiveness, I think we

need to be realistic about how we use comparative effectiveness. Realistically, we need to use it as a reference for how physicians treat their patients, but it should not supplant the individual physician's judgment as a hard and fast rule for healthcare delivery.

Let us not forget when Medicare was introduced some--in 1965, that in the statute itself it said nothing in this legislation, shall construe that the Medicare legislation will interfere with the doctor's ability to treat the patient. I think we would be wise to keep that in mind today as we go through this.

I will yield back the balance of my time.

[The prepared statement of Mr. Burgess follows:]

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Mr. {Pallone.} Thank you.

Gentlewoman from Illinois, Ms. Schakowsky.

Ms. {Schakowsky.} Thank you, Mr. Chairman.

I just wanted to point out that no longer is the problem of the cost of healthcare, access to healthcare a reserve for the 47 million people that don’t have health insurance but is really affecting so many more.

First, we know that only giving someone an insurance card is not going to fix our healthcare problems. The Commonwealth Fund estimates that 25 million insured people can’t afford the gap between what their insurance covers and what their medical bills demand, and that number is growing exponentially every day.

Second, in 2007, healthcare accounted for 17 percent of our GDP, but our healthcare system ranked last or next to last on five dimensions of a high-performance health system; access, efficiency, equity, quality, and healthy lives. And so we have to be starting to pay for quality care.

And finally I want to talk about transparency. With all our current technological advances there is no reason why we cannot access information about insurance practices. As Diane Archer will outline in her testimony, it is impossible to hold insurers accountable without knowing, for example,

how they calculate premiums and other cost-sharing requirements, their denial rates, loss ratios, their prescription drug rates, the in-network versus out-of-network care rates. My office recently met with a group of insurance agents who complained of being unable to get this type of insurance from insurance plans. That was insurance agents. How can insurance agents accurately represent and sell insurance products if they don’t have all the relevant information consumers need to make coverage decisions.

We can create a system that is not only accessible, one that is efficiently and properly focused on providing quality care.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Ms. Schakowsky follows:]

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Mr. {Pallone.} Thank you.

Gentleman from Iowa, Mr. Braley.

Mr. {Braley.} Mr. Chairman, thank you for holding this hearing on the issues of cost and value in our healthcare system.

Creating a healthcare system that emphasizes quality of care over quantity of patients seen has been a long-standing priority of mine. Studies regularly show that the State of Iowa ranks right at the top of our Nation in terms of quality of care, but Iowa healthcare providers receive some of the lowest Medicare reimbursements in the country. The current fee for service system incentivizes the quantity of patients seen over quality of care, which results in higher costs and an emphasis on the bottom line rather than patient outcomes.

A system that provides clearance centers for quality of care would also improve access to care for patients in rural America. Despite the well-documented success of Iowa’s healthcare system, Iowa healthcare providers lose millions of dollars due to outdated geographic practice indexes. These antiquated figures ensure that some parts of the country receive drastically-lower Medicare reimbursement rates than other parts and have led to a shortage of doctors and medical personnel in rural America. There is already a physician

shortage in Iowa, and the existence of these gypsies provides further disincentives for treatment of those who need it most, Medicare patients.

We need a system that emphasizes quality, efficient care with value-based measures. This will reduce costs and improve America’s quality of care.

And I yield back.

[The prepared statement of Mr. Braley follows:]

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Mr. {Pallone.} Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. {Baldwin.} Thank you, Mr. Chairman. I really want to commend you, Mr. Chairman, for this series of hearings that you have held, making healthcare work for American families. We have touched on a wide array of issues of great importance as we look at national healthcare reform.

Over a period of a few months President Obama during the transition invited Americans to host and participate in healthcare community discussions to talk about how to reform healthcare in American, and these discussions showed us, showed that more than anything Americans are worried about costs. And it is no matter whether they have insurance or not. The financial burden of healthcare is a daily concern. It is something that keeps them up at night.

This situation obviously cannot persist, and we have this tremendous opportunity in front of us right now to reform our system and rebuild it for the next generation.

And Mr. Chairman, I look forward to the opportunity to work closely with you over the coming months to produce comprehensive healthcare reform legislation that addresses these very significant concerns of our constituents. So thank you for this series of hearings and our hearing today.

Thank you to our witnesses.

[The prepared statement of Ms. Baldwin follows:]

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Mr. {Pallone.} Thank you.

Gentlewoman from Ohio, Ms. Sutton.

Ms. {Sutton.} Thank you very much, Mr. Chairman, and thank you for holding this important series of hearings.

Today's hearing, saving money, saving lives, will address the cost of healthcare and transparency in our healthcare system. You know, we have all, we are all aware that American healthcare is the most expensive in the world. The Kaiser Family Foundation's March, 2009, report on healthcare costs notes that the U.S. spends 90 percent more than any other industrialized country on healthcare.

With such high costs one would think that our healthcare system would be exceptional, but as indicated in previous hearings there are serious access issues in this country resulting in 47 million Americans without healthcare. Families USA estimates that each day in Ohio two Ohioans die because they lack health coverage.

I look forward to hearing from our panel today as they address ways in which our healthcare system can cut down on costs while maintaining and even enhancing quality. I also look forward to hearing from our panelists as they address the role of transparency in our healthcare system, and I thank you, again, Mr. Chairman, and yield back my time.

[The prepared statement of Ms. Sutton follows:]

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Mr. {Pallone.} Thank you.

Our Ranking Member, the gentleman from Texas, Mr. Barton.

Mr. {Barton.} Mr. Chairman, I am just going to submit my statement for the record, but how can we oppose a hearing entitled, ``Making Healthcare Work for American Families: Saving Money and Saving Lives?'' Can’t get any better than that.

[The prepared statement of Mr. Barton follows:]

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Mr. {Pallone.} Thank you for a compliment on our message.

Mr. {Barton.} Glad to be here, and I want to especially welcome Mr. Goodman, who is a good friend of mine, and we are glad to have a conservative viewpoint on this panel.

Thank you, Mr. Chairman.

Mr. {Pallone.} I think that concludes opening statements by members of the subcommittee.

We will now turn to our panel. A word of warning. We might have a vote and have to interrupt but hopefully we will get, you know, we will get through the whole panel.

Let me welcome you and also introduce each of you. Starting on my left is Dr. Jonathan Skinner, Professor of Economics at the Dartmouth Institute for Health Policy and Clinical Practice. And then we have Dr. Christine Cassel, who is president and CEO of the American Board of Internal Medicine and the ABIM Foundation. Dr. John Goodman, who is President and CEO of the National Center for Policy Analysis. Dr. Bruce Sigsbee, President Elect of the American Academy of Neurology. Dennis Smith, who is Senior Research Fellow in Healthcare Reform at the Heritage Foundation. And Dr. Jerry Avorn, who is Professor of Medicine at Harvard Medical School.

We have--each of you, we ask you to give 5-minute opening statements, which obviously become part of the record, and then when you are done, we will have questions from our members again.

Dr. Skinner.

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^STATEMENTS OF JONATHAN SKINNER, PH.D., PROFESSOR OF ECONOMICS, THE DARTMOUTH INSTITUTE FOR HEALTH POLICY AND CLINICAL PRACTICE; CHRISTINE K. CASSEL, M.D., PRESIDENT AND CEO, AMERICAN BOARD OF INTERNAL MEDICINE AND ABIM FOUNDATION; JOHN GOODMAN, PH.D., PRESIDENT AND CEO, NATIONAL CENTER FOR POLICY ANALYSIS; BRUCE SIGSBEE, M.D., M.S., PRESIDENT ELECT, AMERICAN ACADEMY OF NEUROLOGY; DENNIS SMITH, M.P.A., SENIOR RESEARCH FELLOW IN HEALTHCARE REFORM, THE HERITAGE FOUNDATION; AND JERRY AVORN, M.D., PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL

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^STATEMENT OF JONATHAN SKINNER

} Mr. {Skinner.} Thank you, Mr. Chairman, and distinguished members of the committee for the invitation to join you today.

Variations in per capita healthcare spending are now well recognized.

Mr. {Pallone.} We will have you speak and then we will have to break after you. So please continue.

Mr. {Skinner.} Less well known is that growth in spending has also varied dramatically across the United States as we have shown in slide one.

[Slide]

Had Miami Medicare spending during 1992, to 2006, been as restrained as San Francisco’s, its cumulative savings would have been enough to buy a new Cadillac Escalade for every elderly person in Miami, thus solving both the problems of Medicare and the problems of the auto industry.

The variation in growth rates may appear small, ranging from 5 percent in Miami to 2.3 percent in Salem, Oregon, but compounding makes a huge difference. If all U.S. regions scaled back their growth rates by just over 1 percentage point as San Francisco already has done, the Medicare Program would save more then $1 trillion by 2023.

What explains higher spending? Almost all of the differences in spending across both regions and academic medical centers are due to the greater use and what we refer to as supply-sensitive services.

[Slide]

Next slide. Medicare royalties in higher-spending regions are hospitalized more frequently for conditions that could be treated outside the hospital, see physicians more frequently, are referred to specialists more often, and have more physicians involved in their care.

And more care isn’t always better care. Patients in high-spending regions report being less satisfied.

Physicians describe greater difficulty communicating with other physicians or maintaining adequate continuity. Health outcomes such as survival following a heart attack are no better or worse, or sometimes worse in high-spending regions.

What is going on? We believe that the lower-quality care is largely because the payment system reinforces the fragmentation of care. Many medical decisions are in the gray area where judgment is required and physicians follow local norms. Income pressures on both hospitals and physicians motivate the purchase of new, profitable technologies and the referral of more patients to specialist or to the hospital.

To discourage these expensive treatments with little benefits, it is important to get the prices right. But it is also important to pay attention to quantities. Until the Dartmouth Atlas came along, no one knew that an in Elyria, Ohio, the rate of cardiac stents, a common and expensive procedure to reduce blockage in the heart, was three times the rate in neighboring Cleveland and seven times the rate in Pueblo, Colorado.

On average Medicare enrollees at the NYU Hospital spend more than a month of their last 6 months in a hospital bed compared to just 15 days at the University of Rochester. The current Medicare system is like contracting with a new

homebuilder, agreeing on the price per square foot, but letting him decide whether to build you a mansion or a cottage.

What is the solution? I think a necessary first step is the formation of accountable care organizations or ACOs. An ACO is a local network of providers that can manage the full continuum of care. It must be sufficiently large to accurately measure quality and expenditures, yet small enough to be manageable. Primary care or multi-specialty networks and intergraded delivery systems are all examples of shovel-ready ACOs. Our research has shown that the formation of ACOs would require little disruption of current physician referral patterns and that almost all physicians and hospitals could feasibly participate in such networks.

My colleague, Elliott Fisher, has written about the path forward in creating these networks. I want to talk about the potential of ACOs in extracting some of that $700 billion in estimated waste for U.S. spending on healthcare.

The obvious sources of savings are the high-cost regions where per capita Medicare expenditures are nearly double the national average. One could cap payments for a small number of outlier hospitals with off-the-charts expenditures or cut reimbursements for high-cost providers who don’t participate in ACOs. I expect few hospitals will find these restrictions

binding since there are so many avenues for high-cost hospitals to scale back spending and thus avoid penalties.

Another approach is to restrain the growth rate in spending. Elsewhere, we have described a plan to share savings with ACOs able to ratchet back growth in healthcare costs. This approach encourages cost-saving technology and discourages investment in gray area healthcare with high-profit margins and uncertain benefits. These policies have the advantage of not penalizing even high-cost providers, but they do not deliver cost savings until future years.

In sum, I believe that accountable care organizations are central to claiming some of that $700 billion in wasted healthcare spending. While I recognize the practical challenges, it is hard to see any other approach generating the magnitude of savings we need.

[The prepared statement of Mr. Skinner follows:]

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Mr. {Pallone.} Thank you, Dr. Skinner.

We have three votes, so probably about half an hour. Five? Five. Okay then. We are talking about probably at least 45 minutes, maybe even an hour. Maybe even an hour. But obviously we need you to stay here, so we will reconvene after the five votes.

The subcommittee stands in recess.

[Recess]

Mr. {Pallone.} The subcommittee will reconvene. We left off with the--and I apologize. I thought an hour but it ended up being more like an hour and 15 minutes, I guess. We heard from Dr. Skinner, so next is Dr. Cassel.

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^STATEMENT OF CHRISTINE K. CASSEL

} Dr. {Cassel.} Thank you, Chairman Pallone and Ranking Member Deal. I really appreciate the invitation to testify about approving healthcare value. My name is Christine Cassel. I am a board-certified internist and geriatrician and president of the American Board of Internal Medicine and ABIM Foundation.

ABIM certifies about one-third of all practicing physicians in the United States. We have the largest of the 24 certifying boards that constitute the American Board of Medical Specialties. The certifying boards are independent, non-profits that do not accept industry funding. We test, monitor, and certify that individual physician specialists have the knowledge and skills required to practice in their designated specialty.

Because growing research demonstrates that higher standards for doctors means better quality for patients, board certification standards are recognized as an important component of the accountability frameworks of both public and private payers.

So I very much appreciate the committee’s leadership in examining the link between quality, cost, and value in our

healthcare system. I want to make three points in my testimony today.

First, while there are abundant opportunities to improve value across the healthcare system, the gap is widest and most distressing among those with multiple chronic conditions and those facing the end of life. Second, well-designed delivery system innovations can help to close that gap, and third, the success of delivery system innovations stands or falls in large part on the shoulders of highly-trained and accountable physicians and teams of healthcare professionals.

More than half of Americans have at least one chronic illness, and chronic diseases as this committee knows accounts for a third of the years of potential life loss before age 65 and is the single biggest challenge in our growing elderly population. As we know, the problem is not the lack of spending. More than 75 percent of our $2 trillion healthcare bill is spent on chronic disease care. Too often the problem is failure to deliver the right care at the right time and importantly, to coordinate care across the complex care needs involving multiple providers and settings in a patient-centered way.

In fact, according to MedPAC, Medicare could save $12 billion a year by reducing unnecessary hospital readmissions, improving care transitions and care coordination, and

enhancing primary care. A more patient-centered approach, especially to palliative and end-of-life care could also contribute greater value to our healthcare systems. Research shows that when patients' needs and preferences are the focus of care decisions, fewer resources are spent on aggressive and futile technical interventions. Patients receive more timely referrals to hospice care, and patients and their families have better quality of life in the days that remain.

Payment reform needs to support the physician who has the skills, the evidence base, and the relationship to make this happen.

As this committee also knows models to improve care for patients with chronic conditions and those at the end of life are now being developed and tested, and we are hearing about some of those today.

In 2008, the American Board of Internal Medicine, along with ten other specialties, began recognition of a new specialty of medicine in palliative and hospice care so that patients and payers could be more confident of the provider's skills. Patient-centered medical homes also hold out the potential to simultaneously reduce costs and improve quality. The concept promotes efficient use of office practice design as well as professional recognition and remuneration of the primary care physicians and geriatricians who are needed to

manage and lead such practices.

However, these very same professionals are in very short supply. A study last year showed that 2 percent of graduating medical schools, graduating medical students expressed interest in seeking careers in primary care internal medicine. Given this reality medical homes and related models are going to need to make the very best use of the generalist physician skills that we can get to manage these complicated patients and to use the talent and experience of other members of the clinical team to support prevention and coordination. Those team skills are also not in common supply in our medical world or in our medical--or taught well in our medical schools.

The medical home model to date has focused mostly on system-level improvements like health information technology. These are necessary, but they are not sufficient. For the medical home concept to deliver on its promise, the designers have to create incentives for long-term relationships and effective utilization of care between the highest-need patients and their physicians.

Primary care and geriatric physicians will need the tools, both incentives and accountabilities, skills, and experience to support care coordination beyond the confines of their practices. The seven to ten to 15 other specialists

that the patient is also seeing also need incentives to share the information that they have with that medical home, and the medical home also needs two-way communication, not just with physician specialist, but with hospitals, nursing homes, rehab centers, and other community resources.

Finally, I would like to suggest that specialty board certification and maintenance certification offers a way to enhance, improve the physician's skills and to ensure that they can continue to keep up to date to manage complex patients. What we require of physicians to maintain their certification includes regular, formal skills testing, practice monitoring, and self-evaluation and quality improvement, including tests of diagnostic skills, clinical judgment, systems management, and the translation of medical knowledge and evidence into practice. All of these tools use national quality forum endorsed measures where they exist.

Now all leading health plans put a premium on physicians who participate in this process in their reward and recognition programs. We have also been involved recently in discussions with Senate staff to recognize this process of maintenance and certification in the pathways within the Medicare PQRI Program, and we look forward to working with you and would ask the House leadership to give this idea similar consideration as a way of reducing the burden on

doctors of redundant measurement requirements and a way of enhancing evidence-based approaches to setting levels for quality of care.

So in conclusion stronger infrastructure, better connectivity, and physician payment reform are all essential elements of the patient center medical home, as well as effective healthcare reform. But at the end of the day my message to you is that the quality and value of healthcare for complex patients also rests in great part on the skills and judgment of the physician in relationship with the patient.

Thank you very much.

[The prepared statement of Dr. Cassel follows:]

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Mr. {Pallone.} Thank you, Dr. Cassel.

Dr. Goodman.

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^STATEMENT OF JOHN GOODMAN

} Mr. {Goodman.} Thank you, Mr. Chairman, members of the committee. I promise to stay on time.

All bureaucratic systems tend to show a similar pattern, whether it is the National Health Service in Britain or Medicare in Canada or the Texas Public School System or the U.S. Healthcare System. In all these systems what you tend to find is a sea of mediocrity punctuated by little islands of excellence.

In healthcare people point out that if everyone in America went to the Mayo Clinic for his healthcare, we could cut the national healthcare bill by a fourth, and quality would go up. If everyone went to the Intermountain Hospital System in Utah, we would cut spending by one-third, and quality would go up.

So invariably in all these systems people ask, well, why can’t everybody else be like the islands of excellence. There are two characteristics of these islands. Number one, they tend to be randomly distributed, and that is because there is no reward for excellence and no penalty for mediocrity, and two, whatever makes them good is originating on the supply side of the market and not on the demand side.

And the problem for us is that we don’t understand why the good organizations are good, we don’t know how to replicate them, and we don’t have any model that tells us how to manipulate them.

Now, despite this fact there is huge interest in pay for performance systems in Washington elsewhere around the country, and yet we have been doing this in education for almost 2 decades now, certainly in my State of Texas we have been doing it, and I can’t see that we have had any positive results.

Now, if it is true that everything that anybody can point to that they like in healthcare is originating on the supply side of the market and no one can point to any example where a demand side reform is causing any commendable response, then it would seem to me that we ought to focus on how we get these kinds of supply-side changes, and I have three recommendations.

First, we should stop penalizing what we like. When Mayo Clinic saves money for Medicare, it is losing money for itself. Same for Intermountain. When the Geisinger Health System, which was in the Washington Post just this week, offers a warranty on its heart surgery so that the buyer doesn’t have to pay again if they screw up and there’s a readmission to the hospital, Geisinger is saving money for

Medicare, but it is losing money for itself.

So we need to turn this around. Medicare ought to be willing to say at least we will pay 50 cents on the dollar when you are saving us money. So that is reform number two.

The second thing Medicare needs to do is tell all the other hospitals what it has done. We want other hospitals to know that we have rewarded innovations that improve quality and reduce costs, and then invite all those other hospitals not to copy what Geisinger has done because we don’t know that Geisinger is really doing it the best way, but to come forward with their own suggestions for repackaging and repricing their services.

And number three, we need to extend this offer to every hospital, every doctor, everybody on the provider side. Medicare ought to be open for business. It ought to be open to hear from any provider who suggests a different way of being paid with three rules. Number one, cost to the government cannot go up, the quality of care to the patient cannot go down, and they need to tell us 6 months out or 12 months out how we are going to measure all this to make sure we have abided by rule one and two.

This is a totally different approach then that pay-for-performance approach. What I am suggesting is let the supply side of the market which knows far more than anybody on the

buyer's side, let them to decide and propose how we improve quality and reduce costs and every doctor in America can think of ways that you can reduce costs and eliminate waste. It is just under the current system they have no incentive to do so.

Both in education and healthcare we have the same fundamental problem. The entity that pays the bills is not the entity that benefits from the services, and that is the source of the inefficiency that we find. In healthcare wherever there is not a third party, wherever there is no Medicare, no Blue Cross, no employer, things actually work pretty well. If we look at those markets like cosmetic surgery, lasik surgery, the walk-in clinics in shopping malls, tele-doc, which does telephone consulting, the concierge stocks, medical tourism, and all these markets where it is just patient and doctor and no third-party payer. You always find price transparency, you often find quality transparency, you have cost control, you frequently have electronic medical records, electronic prescribing. Doctors often are using telephone, e-mail. In other words, doctors dealing with patients on their own tend to deal with patients the way other professionals; lawyers, engineers, accountants, and so forth, deal with their clients. We need to open up the supply side of the market and encourage this.

This morning, Mr. Chairman, I have talked about freeing the doctor in this system. We also need to free the patient, and I have written about that elsewhere. Thank you.

[The prepared statement of Mr. Goodman follows:]

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Mr. {Pallone.} Thank you, Dr. Goodman.

Dr. Sigsbee.

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^STATEMENT OF BRUCE SIGSBEE

} Dr. {Sigsbee.} Good morning, Mr. Chairman, Ranking Member Deal, and members of the committee. I am here to talk about this morning or actually now this afternoon about how realigning incentives within the healthcare delivery system will lead to better quality of medicine and will service the Medicare population.

As an introduction, I am a practicing neurologist. I am also medical director for a nearly 50-physician multi-specialty group and responsible for quality in that group, and I am also incoming president of the American, president elect of the American Academy of Neurology.

Right now as many have already pointed out this morning we have misaligned incentives within the healthcare delivery system and payment structure. And in very real sense we have procedure-centered care, not patient-centered care. And the focus should be on what is important for the patient, for the individual patient. I am not suggesting that we cut payment for proceduralists, but what I am suggesting is that we need to adjust the payment system so we have a balanced workforce.

There are certain consequences of the current incentives that have been reviewed before, and I am sure you have heard

1050 testimony on, but at least from my own perspective as a
1051 neurologist where we are responsible for taking care of
1052 diseases that are important to the Medicare population such
1053 as Alzheimer's, ALS, Parkinson's, stroke, we are suffering
1054 the same workforce crisis that primary care is suffering.
1055 Also, intrinsic in the current fee schedule is actually
1056 not just a lack of incentive but barriers to quality.
1057 Certainly it is not all valued by the payment structure. I
1058 have had physicians tell me that they did not want to get
1059 involved with quality efforts because it took them away from
1060 revenue generated at activities.
1061 And also, if you look at it, ambulatory quality systems
1062 are still in their infancy. Unlike hospital quality systems
1063 that have developed over the last several decades, we are
1064 still trying to figure it out. It takes a great deal of
1065 effort and energy to make these systems work. And they also
1066 are quite costly. Health information technology is an
1067 important tool. You also need healthcare coordinators and
1068 others to really make it work.
1069 PQRI in my view is an abject failure. Pay for
1070 performance as it currently exists does not encourage, as it
1071 is viewed as ineffective quality measure, but quality can be
1072 done very effectively, and I would like to give you at least
1073 my own personal story on this. I am a member of a three-

physician neurology group. We have a joint commission stroke center at our hospital. Before we went through the certification process, we thought we were doing a great job of taking care of stroke patients until we actually started measuring what we were doing, and we were not doing as well as we thought or expected of ourselves. By placing the quality systems in place, by constantly monitoring, by developing a system of care that includes EMTs out in the field, all the way through rehabilitation, we are taking very good care of those patients. We consistently exceed national stroke center benchmarks in terms of the quality of care that we provide. And it is that kind of in-the-community effort that is really required for effective health, for quality measures.

And as far as an example, and to really look at a payment structure and at least in terms of the incentives, what is really important, and you have heard about accountable healthcare organizations, medical home, but what you are really trying to do is create a system where you are trying to incent the behaviors that are really important for patient care. Certainly productivity is important, not sort of the hamster mill of turning but you need certainly enough physician work to have access for the Medicare population. Quality is critical, patient satisfaction and really a good

experience with the healthcare delivery system and confidence in the care that they are getting, but also you need to encourage the physicians to work on improving the systems of care. Care is no longer just one physician and one patient. It is across the whole system of care. For example, the stroke center, we have trained the EMTs so they can recognize stroke and deal with it appropriately.

So you really have to have a whole system involved, and it has to be patient-centered care. And how do you create those incentives? There is a lot of discussion about healthcare delivery systems. In fact, in the last four or five years there has been a great deal of experience with creating physician compensation systems, which we are really talking about, and creating a balanced way of trying to incent physicians to do exactly the kinds of things that I am talking about.

In fact, they have developed and most places that now employ large groups of physicians have moved to what they call a blended compensation system, which includes both a salary component as well as an at-risk component that can be determined not based on only productivity but also on quality, patient satisfaction, and also what is termed citizenship, which is contributing to healthcare delivery systems.

And no matter what system you involve, if you don’t implement the proper incentives in that system, it will not really be an effective way and really incurs the kind of healthcare that we would like. So based on this experience I am recommending that no matter what system we move ahead with that there be a blended payment structure that includes the right incentives which not only will be good in terms of cost control but will be good for patients.

Thank you.

[The prepared statement of Dr. Sigsbee follows:]

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Mr. {Pallone.} Thank you, Dr. Sigsbee.

Mr. Smith.

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^STATEMENT OF DENNIS SMITH

} Mr. {Smith.} Thank you, Mr. Chairman. It is a great pleasure to be with you again. First let me hasten to say new views, my testimony are my own. They don’t represent the position of my current and certainly not the position of my former employer, the Federal Government.

I do perhaps have a little bit different perspective than my colleagues here on the panel in terms of the experience of actually running these programs for the last 10 years or so of my life. It gives me perhaps a different perspective seeing Medicare and Medicaid, two government health plans, up close and personal.

And one of the things that I think is striking to me is that they have to be part of the equation as well. Medicare and Medicaid account for approximately 45 percent of healthcare spending today. They are going to go up to 50 percent. So any idea that we can do this without involving, reforming the entitlement programs would seem to me it doesn’t work.

It has been 15 years since Washington tried this sweeping types of reform that is being currently discussed today, but in that time states have been trying to do this.

We have states as diverse as California, Massachusetts, Oregon, Tennessee, Hawaii, Maine, and Washington have all struggled with universal care. I suggest that we learn from them since they have already tried it and see what lessons there are, and then certainly we have Medicaid itself, the experience of the last several years in dealing with the great growth in eligibility and Medicaid, et cetera. So there is a great deal to learn from.

I think one of the things also is the expectations. Right now and I think in all of these states the promise was being made to the people not only those who were uninsured but the people who were insured as well. The promise to them was this was going to be cheaper for everybody, and everybody's going to save. We are hearing that today. The President has made the promise that the average family is going to save $2,500 on average. That is $2 trillion over a 10-year period of time. In recent, the last few weeks and months we have made commitments to spend another trillion dollars over 10 years on healthcare, so it seems to me right off the bat we are $3 trillion apart from where the American people think we should be in terms of addressing the issues of healthcare.

Again, I think we need to try an approach of lowering the cost first then it will become more attractive to people

and that they will actually purchase it. I think the experience especially in California and Tennessee are very important lessons of the day.

First, dealing with the issue of mandates, what does that do to the cost of care. I think the discussion in California was very reflective since we have that in recent memory where you started off with mandates, mandate participation, then you were mandating a particular type of coverage, then you were also mandating how much people were actually going to spend on it. You became, you started a circular affect in which the mandates actually kept driving the price tag even higher yet. And I think that that in itself contributed in large part to why reform in California failed.

Tennessee as well. Tennessee, the story of TennCare was not started as a healthcare issue. It was started as a budget issue, and accordingly, TennCare from the very beginning I think was crippled and doomed to failure. It took a lot of years. It spent a lot of money before the program itself was dramatically changed.

So in terms of solutions, where do we look? From my way of thinking look at what model is actually being very successful in getting people covered, although in recent years we have had some struggle, but the dynamics anyway of

employer-sponsored health insurance. What advantages do they have? First, they have the advantage of the tax code in which individuals have a tax advantage to buy it through the employer. So level the playing field between the individuals buying it on their own and individuals who are buying it through employers.

Secondly, the dynamics of group purchasing. Individuals when they go to the marketplace on their own, they are all on their own. They are all by themselves. Well, in group purchasing, in employer sponsored, you are in a group. You get the discounts that is offered to the group, and you do not have the underwriting that goes on in the group setting.

The entitlement reforms themselves, as I said, Medicare and Medicaid in my mind have to be a large part of it. My colleague at the end of the aisle talked earlier about the disparance in Medicare payments between Florida and hospitals, between Florida and San Francisco, but he didn’t say why. The reason why is government actually interferes in the marketplace. We see time and time again in Medicare and in Medicaid where government artificially steps into the market, allows one hospital, for example, to leap three counties away so they get the higher reimbursement of an MSA from a higher payer.

So we are interfering in the market all the time is

part--so I think part of the solution is resisting that temptation. We have plenty of quality initiatives in Medicare. We have got I think in many respects the things that we are discussing today have been discussed for a great, for a long period of time. There is in many respects nothing new under the sun in types of those issues, but I think the one thing that would be particularly helpful is transparency.

People should know what they are actually paying for, what they are actually buying. We tried this in the Deficit Reduction Act of 2005, where we tried to bring transparency to prescription drugs and ended up being sued by the pharmacy community who didn’t want those drugs to become public. So the transparency itself I think is a great advantage, a very important element that is absolutely missing.

And finally I think the long-term care in Medicaid, we are unnecessarily paying, spending too much on long-term care for services that people don’t really want. Talking to people with disabilities, they want to be in their own homes, in their own communities, not in institutional care. So we have to fix the F-map in Medicaid to rebalance the system.

Thank you very much.

[The prepared statement of Mr. Smith follows:]

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Mr. {Pallone.} Thank you, Mr. Smith.

Dr. Avorn.

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^STATEMENT OF JERRY AVORN

} Dr. {Avorn.} Mr. Chairman, members of the committee, thank you for the opportunity to testify today at this very important time for the Nation’s healthcare system. My name is Jerry Avorn. I am a professor of medicine at Harvard Medical School, and for nearly 30 years my research has focused on the effectiveness, safety, and affordability of prescription drugs and how those drugs are used by doctors and by patients. I have taught and practiced geriatrics and primary care internal medicine at several of the Harvard teaching hospitals since 1974, and I am the author of the book, ``Powerful Medicines,'' which deals with many of these concepts.

We doctors badly need more information about the drugs we prescribe. Our ability to take the best possible care of our patients is severely hampered by a lack of this information. There is also a need for our patients to be astute consumers of the medical choices available to them, and the Nation increasingly expects those who pay for healthcare to be able to make the smartest possible choices. The information gap I will discuss today limits decision making on all of these fronts.

My history and by law the FDA is not mandated to evaluate new drugs or devices against other treatment options. Its enabling legislation requires it to approve a drug for marketing if the manufacturer demonstrates effectiveness, which may simply mean that it works somewhat better than a dummy pill.

But I have never had a patient say to me, Dr. Avorn, please prescribe me something that is a little better than nothing. Patients and doctors want to know the best treatment for a particular condition, but that isn’t the evidence that the pre-approval testing system was ever designed to collect. Many observers feel that changing the legal standards for the drug approval process would be infeasible, and many others argue that it would be undesirable.

In any case, once a product is marketed, important new information about its safety or effectiveness could be collected, which would be very important for doctors and patients to know about but which is beyond the purview of the initial approval process itself. Once a new product is on the market its manufacturer is likely to launch a massive sales campaign. The pharmaceutical industry spends much more of its revenues on marketing and on promotion than it does on research and development. The most costly new products are

the ones that are most aggressively advertised to doctors and to patients whether they represent a real advance or not. A time-tested generic drug may be the most effective treatment for conditions like high blood pressure or diabetes, and generics often have the most well-established safety records as well and are likely to be the best value economically by a long shot.

But the profit margins on generics are wafer thin, so their manufacturers don’t have the resources to take out expensive ads on the evening news or to send perky salespeople to doctors’ offices to offer us free meals and gifts to persuade us to prescribe those drugs.

This skews the use of medications as well as other interventions towards the costliest choices, even when they are no better than the alternatives and may even be worse. Other economic incentives can take hold when expensive treatments or tests like chemotherapy or MRI testing become profit centers of their own for the doctors who prescribe them or order them.

The manufacturers of drugs and devices are investor-owned companies, not public health agencies. That is not a moral judgment. It is just an economic fact. Given these companies’ responsibility to maximize return to their shareholders, you would be naïve to expect these companies to

be a good source to fund and disseminate studies which could sink one of their products.

There is a clear and embarrassing track record of drug makers actually suppressing the results of research if it showed problems with their products. This has happened with anti-depressants like Paxil, the cardiac surgery drug Trasylol, the cholesterol medication, Bacol, and many others. And there are examples of this problem from nearly every field of medicine.

At the beginning of this decade my own research group wanted to study the apparent link between Vioxx and heart disease while that drug was still on the market. We had to seek funding for the research from its manufacturer, Merck, since there was no little federal support available to do this research. When our study found a clear link between Vioxx and heart attack well over a year before it was taken off the market, Merck tried to persuade us to deemphasize some key results, take a co-author off the paper, and then they dismissed the very methods that they had previously supported. Clearly this not the ideal way to fund studies of drug safety and comparative effectiveness.

Until now it has not been anyone’s job to determine how well alternative treatments work and how safe they are compared to each other. We are often totally in the dark as

doctors when we try to choose between several drugs for the same condition since those studies are rarely done. Our patients probably think that we are playing with a fuller deck than we are. Perhaps members of Congress think so as well. We are not. As bad as the situation is for drugs, this informational gap is even worse for other kinds of healthcare intervention. A new medical device like a pacemaker or deliberator or artificial hip mostly needs to show that it is not dangerous. Not how well it works or whether it is better than existing products. And new surgical procedures or new imaging studies like MRIs and CAT Scans don’t have to show that they benefit patients at all.

The worst consequence of this information deficit is that it prevents us from taking the best possible care of our patients. But at a time when the Nation can’t afford to provide healthcare for all of its citizens and even people with insurance as we heard earlier have problems paying for that care, the economic aspect of this problem is also quite important.

The U.S. as you heard earlier today has per capita healthcare costs that are the highest in the world by a great deal. Yet our medical outcome data are overall no better than those of many other industrialized countries and often much worse. In these rough economic times when more and more

people have to pay for healthcare out of pocket, high costs can mean no care at all, and for Medicare and Medicaid not knowing which treatments work best and which have the best value and which are safest leads to patient outcomes that are worse than they need to be and costs that are increasingly unaffordable for the Federal Government and therefore the taxpayer as well as for the states.

There is a solution for this problem. It is based on the same concept that underlies all of modern medicine, and it is the reason that we are not still using leeches and purgatives to treat most diseases. It is the idea that well-conducted scientific studies can show us which treatments work best for a given medical problem and are the safest. This information can be gathered through well-established methods of randomized trials, as well as observational studies. The latter kind of research, which my group at Harvard performs, can review the clinical experiences of millions of people to learn how well similar patients did with different treatments.

These kinds of observational studies can also enable us to ask questions about special sub-groups of patients such as minorities or children or the very old; the very groups that are often under-represented or even excluded in the clinical trials that drug manufacturers perform to win FDA approval.

This kind of research is a public good like clean air and good highways, which needs to be supported by government. The private sector is simply not going to do the research to identify drugs that are absurdly mis-priced or toxic any better than the private sector was able to identify financial instruments that were absurdly mis-priced or toxic.

This kind of applied research is not something we should fold into the missions of the National Institute--

Mr. {Pallone.} Dr. Avorn, I am sorry.

Dr. {Avorn.} Yes, sir.

Mr. {Pallone.} You are 2 minutes over, so if you could kind of summarize.

Dr. {Avorn.} Okay. I will wrap it up.

There is a way that we can get this information to physicians as well as make sure that it is out there in the literature. For a number of years my colleagues and I have been doing a process called academic detailing, in which we bring information to doctors much as sales reps do for the drug companies. The idea is that the states, in this case several states in the northeast, support nurses, pharmacists to go to doctors' offices and bring information that is not about sales but is just about the best possible way of taking care of patients. And we have shown over the years that this is a way of improving care and actually paying for the

program’s cost.

In summary, there are ways in which we think that we as physicians can take better care of our patients and save money for the healthcare system at the same time. Sandra Cole on the Senate side has introduced a bill to support this academic detailing outreach to doctors. I am pleased that members of this committee, Representative Waxman and Pallone, have also introduced a bill that would do the same thing on the house side. The goal is to get us doctors the information we need to take better care of patients, improve those outcomes, and save money at the same time.

Thank you.

[The prepared statement of Dr. Avorn follows:]

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Mr. {Pallone.} Thank you, Dr. Avorn. Thank all of you.

We will take questions and start with myself. In each case we have 5 minutes.

My questions actually are of Dr. Skinner. I am trying to get two in here; one about the--his startling statistic about $700 billion in healthcare spending each year is wasted, which is about the size of the economic recovery package that we enacted, and it represents about a third of all health spending.

Now, my understanding is when you talk about $700 billion it is money spent on services that are not effective or that may even be harmful. But if I you would explain. Where does this estimate come from, what do you mean by wasteful spending, and why is this so large?

Mr. {Skinner.} Thank you. That is a great question. That is a big number. We had done some studies at, from Dartmouth that looked at outcomes of say heart attack patients, hip fracture patients, a very large number across the country where we had very good detailed information on how sick they were when they arrived. Heart attack patients are--everybody is admitted to the hospital, you have some good information on how well they are doing, and what we observed some areas spent 60 percent more on these patients,

but they didn’t do any better. If anything, they did a little bit worse, and so we added up the number and came up with a number between 20 and 30 percent for the Medicare population.

We extended that to the general population, the under 65 population, which--and also we, we also viewed this as sort of a lower bound in some way because probably even the most, what we found to be the most effective, cost-effective areas could also probably improve a little bit as well. So--

Mr. {Pallone.} So it is private as well as public? It is not--

Mr. {Skinner.} Yes. We don’t have direct information on private, but we made inferences based on the Medicare population.

Mr. {Pallone.} Now, what do you suggest we do to avoid this waste in passing health reform? I mean, I know you talk about the creation of ACOs, Accountable Care Organizations, that would reward physicians and hospitals for effective management and costs and quality. How would that address the problem? Is that your answer?

Mr. {Skinner.} Well, I think of ACOs in some way as a very flexible approach that enables whatever kind of health reform that comes in to at least get at what we see is the fundamental problem in healthcare, which is nobody is

accountable in the system, that primary care physicians are overworked, they get patients, they send them to the ER if they are, you know, if they can’t deal with them in their offices. There are one or two patients. There is a lot of fragmentation. All of these problems basically are allowed to grow and to cost us money and to result in bad care, and the ACOs are ways to try to solve that.

Mr. {Pallone.} And how would they solve it? Because, you know, I don’t want just another managed care organization. How are they going to help us?

Mr. {Skinner.} Absolutely. I think the last thing we want is to live through the 1990s again with the problems of managed care. I think the improvement over managed care is that this is an example of providers, highly-skilled physicians and other providers working together to try to basically sit down, maybe this primary care physician that I mentioned earlier who may not have admitting privileges at the hospital in sending their patients to the ER, they could actually get together with the people at the ER and figure out more effective ways, more cost, you know, ways to save money when they get difficult patients that come into their door.

Mr. {Pallone.} But are you going to do it by changing the payment system or--I mean, what is the mechanism? What

is the enforcement mechanism?

Mr. {Skinner.} Yeah. No. It is two things. One is you have to get the prices right. This is easy for me to say as an economist, but you also have to pay for the right things. Right now we are paying per MRI, we are paying on the basis of quantities, and so basically Medicare pays whatever people decide to do. What we need to do is pay on the basis of--is reward on the basis of total expenditures. That is prices and quantities.

Mr. {Pallone.} You know, there was an article, I am going to ask unanimous consent to put this in the record. It is an article that is today’s New York Times about this study that finds that many on Medicare return to hospitals.

Without objection so ordered.

[The information follows:]

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Mr. {Pallone.} But are you familiar with that? I mean, is that an example of how we could--that is something that needs to be addressed obviously. Right?

Mr. {Skinner.} Yes. I mean, right now, I mean, another example--that is a very good example. Another example was when a hospital figured out that when people came in with back pain, that if they sent them to see a nurse practitioner, rather than send them home and have them wait to go see the surgeon, then, in fact, most of them, most of the back pain suffers got better and went back to work. But the problem was that the hospital was losing so much revenue because it wasn’t doing as much back surgery. And so they actually--

Mr. {Pallone.} The bottom line is you are going to have to create some sort of financial incentive. I mean, this article talks about a financial incentive for hospitals that, where the person, where they don’t have such a return rate.

Mr. {Skinner.} Yes.

Mr. {Pallone.} And you would do the same thing with doctors and group practices and all that?

Mr. {Skinner.} Exactly.

Mr. {Pallone.} All right. Thank you.

Mr. Deal. Dr. Burgess. Oh, you want to see it? Sure.

Yes. Sure. Go ahead. It was in today's New York Times, and it is, basically says that, you know, that there are a lot of hospitals where they have a high readmission rate under Medicare because they don't give people proper services when they leave so they come back. And one way of addressing it is to, you know, create a financial disincentive for that, for the hospitals.

You are okay? All right. I didn't hear you. I am sorry. Dr. Deal.

Mr. {Deal.} Thank you. Well, you all have been interesting, and you all have indicated the complexity of the issue that we face by the diversity of the subject matter that you have addressed, all of which was within that umbrella of healthcare reform, and I thank you for your testimony.

But it is hard for us to get a handle on all of this, as I think you all understand. I think part of it is that we are trying to figure out objective standards to apply against subjective matters. For example, we have interfered with the private marketplace to the extent that in the private marketplace a patient used to go to the doctor because they knew what his reputation was. You know, he was a better doctor than the other doctor who was in town, and so, therefore, they gravitated to him.

Nowadays, there--and this is the transparency issue in another format, nowadays patients don’t know what their Medicare doctor got paid, they get those billing forms, they can’t decipher that. Even in the private insurance market all they really know is what their co-pay was and what their deductible might be for the whole year. Nobody knows what providers are being paid for. They have no objective matter of judging the results, and what we are doing is we are saying we are going to transfer the ability to make those judgments to either the government through Medicare, Medicaid, and modifications of the reimbursement system based on results. Certainly I think results ought to be what--good results is what we all ought to be looking for and trying to achieve.

Now, in that regard, Mr. Smith, you referred to the fact the President says we are going to save every family $2,500 a year in their healthcare costs. How do we do that?

Mr. {Smith.} Mr. Deal, I think it means moving backwards from where we are because I think what we are--the approach thus far that I have been hearing about is actually going to increase costs rather than lower costs. But I think to start with that a pledge of $2,500, which I think is, that is what is getting the American families interested in healthcare, and I think they expect to deliver on that.

I think we have to change the dynamics of our current entitlement programs. I think that we have to bring about the changes that left to the market will help lower those costs.

As I said earlier, so many times we actually interfere in the market. One of the things, for example, is the tremendous growth in Medicaid and in SCHIP. We have actually taken healthy families and money out of the market. When we did that, we raised the cost for the people who were left in the market. This is the crowd-out affect that we talked so much about in SCHIP.

So I think part of that is to return people back into the market rather than segmenting people off. The beneficiaries I think would benefit that, from that in terms of the continuity of care. I think we unnecessarily drive up costs when you get on Medicaid for the first time, for example, then a child is supposed to go for a checkup. No matter that he just had a checkup a month ago. We are going to insist that we actually drive up the cost of care.

So I think that is a large part of it, and in Medicaid, I mean, we are talking about 45 million lives to put that back into, to put those lives back in the market I think would be at least a stabilizing affect on the market.

Mr. {Deal.} Let me ask Dr. Goodman. Would you comment

about the same thing? How do we save every family $2,500 a year?

Mr. {Goodman.} Well, all of the proposals that I heard from the healthcare advisors, President Obama, all the items they mentioned have been costed out by the Congressional Budget Office, and CBO says there will not be savings in these programs. These are all to my opinion demand-side attempts to try to change how doctors practice medicine. As I said in my testimony, I don’t believe you can have great savings coming from the demand side of the market. We need to free the doctors and the hospitals. They know where the waste is. They know how efficiency improvements can be made, and we need to give them an incentive to do so.

And that, I think what that means is empowering the secretary to allow every hospital to come to Medicare and have a different deal, have a different arrangement. Readmissions--let the hospital have a warranty and so Medicare doesn’t pay for the readmission. But we have to pay more for the initial surgery, and we should be willing to do that because a warranty is worth something.

Mr. {Deal.} Are some the stark anti-kickback provisions an impediment to doing exactly some of those things?

Mr. {Goodman.} They are huge impediments. They may be doing some good, but they do a lot of harm, and so if we are

going to renegotiate and let the providers come forward and say we want to be paid a different way, there has to be a way of getting around those stark restrictions.

Mr. {Deal.} Thank you.

Mr. {Goodman.} That is essential.

Mr. {Pallone.} Thank you.

The gentlewoman from Florida, Ms. Castor.

Ms. {Castor.} Thank you, Mr. Chairman.

Dr. Skinner, your data that shows the variations by region is astonishing, and I am very sensitive to it coming from the State of Florida. South Florida is just infamous. So that we have high-spending regions and low-spending regions, and we can’t really explain this by the difference in illness or prices. There is no guarantee the folks in south Florida are getting, you know, much better quality of care.

So I am particularly interested in your finding that the lower-spending regions rely on primary care physicians to a greater extent. Can you give us a few examples of this and why do you think primary care is more available, or is it more widespread in those regions? Is it simply that in those regions people need more, they have access to a better workforce? Could you lay that out in some detail?

Mr. {Skinner.} Great question. I think understanding

where physicians settle is--and where they decide to live and decide to practice is a fascinating but as yet somewhat not well understood question, because there is a free market in where physicians go.

But it seems to be that in, I guess it seems to be that the approach of the primary care physician is to look at an individual and to think there may be, for example, for chronically-ill patients, there may be different organs which are failing, but let us think about how we can coordinate that care and think about treating the individual.

Whereas I think sometimes the emphasis of a specialist is on that part of the body to which they are most highly trained to understand, and in many cases you want to have a specialist on the job, but I think it can also lend to a large number of--in regions with lots of specialists you can get many, many people treating the same--many different physicians treating the same patient. And there are these what economists actually call network externalities in which I may be doing something as a physician which I think is best for my patient, but I don’t know what all of the other physicians are doing as well, and sometimes the things I do may interact with what they day, resulting in not better outcomes.

And so I think that is the best way I can think of to

explain why in some areas, even within Florida, which is sort of a microcosm of these variations, you can find some regions where lots of people are being treated by multiple physicians, but they don’t seem to be doing any better.

And obviously there is a balance. You need to have specialists in any system, but, on the other hand, in some sense you also want this idea of a medical home where somebody is coordinating all of that care.

Ms. {Castor.} And Dr. Cassel, I have met with a number of physicians, and they will share cases where a patient has come in and gotten a diagnosis and gotten tests, but they want a second opinion, so they go into another physician, they get another set of tests. They go another place. Is there--there must be some answer to controlling, you know, if we are going to have, encourage a medical home but you still want patients to have some flexibility, but there must be something we can do in cost structure and reimbursement structure.

What do you recommend?

Dr. {Cassel.} Well, thank you for that question. There is, indeed, and the medical home concept and the accountable care organization actually are linked, because they have to do with giving somebody the accountability to make sure that that coordination happens.

So, for example, the patient with many complicated illnesses who is seeing ten different specialists, and those specialists don’t communicate with each other, could be taking medications that interact, they could be missing major things, you could end up in unnecessary hospitalizations and readmissions, et cetera. So, you know, you can actually make a patient sicker by too many doctors.

Now, on the other side of the coin, the point that you point out, which is that the informed patient, it is a good thing that patients are asking for second opinions in my opinion. I think that is what we want patients to do to be asking of a surgeon how many of these procedures have you done and what is your complication rate, et cetera. And particularly in the diagnostic arena to making sure that they get the right diagnosis. I believe physicians ought to be open to that, and they ought to welcome that.

In a well-functioning system, though, you would have an electronic record, and you would have relationships with those specialists where you wouldn’t need to do the same test over again just to get another doctor’s opinion. You would share your records with the other doctor, and why should they have to order the same test all over again? Put the patient not only to the expense but to the risk that every medical intervention entails.

So I think you can create an accountability system around this. Part of the problem, both of these notions we are trying to solve is that 50 percent of the physicians in the United States don’t practice in Geisinger or Mayo. They practice in single, solo practice or very small practices where they don’t have that connectedness with their colleagues. We need to create some incentives for them to do that and to share records and to share the wellbeing of the patient around organizing that patient’s care.

Mr. {Pallone.} Thank you.

Gentleman from Pennsylvania, Mr. Pitts.

Mr. {Pitts.} Thank you, Mr. Chairman.

Dr. Goodman, as you know, I am sure many large employers are feeling the brunt of ever-rising healthcare costs, and many companies such as Safeway among others have created innovative ways to lower costs and improve health.

Unfortunately, because many small employers fall under HIPAA requirements they are not able to take advantage of this same opportunity. I would like to know your thoughts on this. Should we change HIPAA to let small businesses take advantage of these opportunities? If so, you know, how would you change the law?

Mr. {Goodman.} I think we should, and in particular I think we need some pretty important changes in how we deal

with the chronically ill, because that is where most of the money I spent. And we need to be able to--employers need to be able to make risk adjustment deposits to the accounts of the chronically ill so the diabetic patient, for example, can manage his own money or the asthma patient can manage his money. A lot of care can be managed by patients in their homes. A lot of care can be self-managed, but if we are going to ask patients to manage their own care, they need to be managing the dollars.

To make that possible you need for the employer to be able to give different amounts of money to different employees, depending on their condition. And we also need a change in health savings account rules so we can get rid of this idea of a deductible. We need to just carve out areas of care and say the patient is going to be responsible for certain things. We are going to put money in the account so he can do it.

And the model for this, interestingly enough, comes from the Medicaid Pilot Program, Cash and Counsel, which is, I think, now in all 50 states. It is hugely popular, patients like it, and I haven’t heard a single criticism of it.

So that needs to be done, and we need clarification from Congress on what employers can do, the large ones as well as the small ones.

Mr. {Pitts.} You also advocate making insurance portable. I believe--how would you or how would allowing people to purchase insurance across state lines at cost, do you believe that, you know, the people can choose the plan that best fits their needs or they need help? How would you change it?

Mr. {Goodman.} Well, I do think we need a national market for health insurance, and of the two questions you asked that is the easier one. Just let insurance sell across state lines the same way life insurance sells across state lines.

The harder issue and the far more important one is how do we make health insurance portable, because I think that is the next really big issue is healthcare, and in some ways for employers the sick patient is like a game of musical chairs. And it is intolerable for the employer, it is not good for the employee.

So much better if employers could make a fixed dollar contribution to a plan that is owned by the employee, which he takes with him from job to job. It travels with him through the labor market, and we proposed a way to do this for the State of Texas, Blue Cross of Texas, and we think it is one way to do it nationwide. Probably I would let the states experiment with ways to convert the small business,

small group market into a market for portable care, but that is really, really important, and I think portability is maybe the most important healthcare issue that you all are you looking at.

Mr. {Pitts.} How about risk pooling?

Mr. {Goodman.} Well, you know, the risk pool is there because we are failing on affordability side, and we are always going to need a risk pool is somebody falls through the cracks and for some reason doesn’t have insurance, has health problems, and so that is a way to get health insurance to those people.

But if you are in a system where you are insured, and you stay insured, and you take your insurance with you, you don’t, you will never need the risk pool. So the risk pool should be there, but they should be used infrequently.

Mr. {Pitts.} Thank you. Mr. Smith, could you speak as to the issue of government plans competing along with private plans and your thoughts on that?

Mr. {Smith.} Yes, sir. I think it is an oxymoron. Government plan can’t compete against the private plans because sooner--then eventually there will be no private plans, because the government plan will eat them all up. There is--it is not a level playing field between government being a competitor in there where it can control benefits, it

can control how much somebody is paying, et cetera. All of the advantages are on their side of it. They clearly would want to advantage itself, and it would create the rules to do so.

So eventually the private plans would not be able to compete. So we would end up later, if not sooner, under a government plan, which I think would be a huge mistake. We have seen experiences of government plans, and I think that the private sector--and when there is real competition and I had mentioned earlier, I think part of our problem is we keep interfering with the competition and say we don’t want competition in many respects. Whether it is specialty hospitals to where doctors can go out and form a group and provide a superior process, government comes along and says, no, we don’t want you to do that. In many respects we don’t want competition against our community hospitals, so we change the rules and bend the rules to advantage somebody else.

So fundamentally I think there is not a level playing field when a government plan is involved.

Mr. {Pitts.} Thank you. I see my time is up.

Ms. {Capps.} [Presiding] Thank you.

Now I turn to Mr. Sarbanes of Maryland for your questions.

Mr. {Sarbanes.} Thank you, Madam Chair. Thank you all for your testimony. There is two geriatricians I think at the table. I spent 18 years working with seniors in the healthcare arena, and so I am very focused on that. Also, I have a district that includes one of the most rapidly-aging populations in the country in one portion of it.

So on the question of the workforce, specifically today if you were trying to encourage somebody to go into that line of work, what are three or four or five things that you would offer them, that you would change that you think would incentivize them to pursue that kind of a career?

Dr. Cassel and Dr. Avorn.

Dr. {Cassel.} Thank you, Congressman Sarbanes. Great question and particularly at this time where all of these models of reform are based on the idea of not just better outcomes but also more efficiency. You are going to have to have somebody who really understands that complexity of the science based and the evidence base and all the skills of working with a team that, as you know well, geriatric medicine involves.

Right now--so the answer is how do you create those incentives? I would say value, respect, and doability, and so value really is reimbursement. I mean, there is--geriatric medicine is now the only subspecialty I know of

internal medicine, you know, we have internists who train and they become cardiologist, and they become critical care specialists, and every time they get an additional training, they make more money. In geriatrics after you do your internal medicine training, you get more training in geriatrics, and you make less money than the internist makes. And so it is amazing anybody does it at all. But the few dedicated people who do it do it because they really find huge rewards in that, and it makes sense to them that the aging population needs this.

So we have to find a way in the payment reform discussions to appropriately value that additional training and that additional skill, and I think there is lots of ways that we can do that, and I would be happy to talk with you and the committee staff more about that.

And the second is respect, and you might find it odd that I put that in there, but I think Dr. Avorn can reinforce this that within the medical profession part of how you are respected is kind of by what the public thinks and what you are paid and that value equals something, some combination of that. And if other specialists really believe that what you bring to the table adds value, then that adds a lot to the respect. Right now it is such a small and in some ways embattled specialty that most specialists don’t have any

experience of working with a geriatrician, they don’t know how, what that can value. The people who understand this now are aging baby boomers who have gone through this now with their parents, and if they can find a geriatrician, they say, oh, my God. I didn’t know they made doctors like that.

Mr. {Sarbanes.} Uh-huh.

Dr. {Cassel.} So we somehow need to create systems, an accountable care organization might be one example of that, where there would be a defined role for that person really taking advantage of their skills, taking care of the most-difficult patients and the most challenging patients. So that is the second thing.

And the third is doability, and this gets back to delivery redesign as well, because right now in the fee-for-service system, in order to actually even just make the expenses of your practice and take home a reasonable salary to support a family, most geriatricians who are in private practice are doing things like Botox and you know, laser skin surfacing, because what Medicare pays them for that complicated coordination of care, helping that patient and family find ways to stay out of the hospital, stay out of the nursing home, keep themselves as functional as they can with their Parkinson’s Disease and all of their conditions, nobody pays them to do that.

Mr. {Sarbanes.} Right. Right.

Dr. {Cassel.} So instead they are wasting all that training doing Botox. So that is a real misuse it seems to me, so I think it actually wouldn't be that hard to do within some of the things that I know the committee is considering within the payment reform.

Mr. {Sarbanes.} Thank you. We just have a few seconds left, Dr. Avorn, if you want to add anything.

Dr. {Avorn.} Yes, sir. Just very briefly, my answers are exactly parallel to Dr. Cassel's. It has a great deal to do with reimbursement. Students come into medical school wanting to be primary care doctors, take care of the elderly, deal with chronic disease, and they come out of medical school looking for residencies in dermatology and plastic surgery. It is because they see their role models and the people who are doing well and being rewarded by the system, both public and private, are the folks who are doing procedures. And the doctors who are simply taking care of chronically-ill people are reimbursed in a manner that makes it virtually unaffordable to do that kind of work.

So I think Medicare and Medicaid, as well as the private systems could do a great deal in moving from a procedure-based reimbursement system, particularly invasive procedures, and toward a comprehensive care of the patient kind of

system. And we have heard about that for a number of ways today.

And then the last point is it also would help if we had a healthcare delivery system that was structured so that the geriatrician like the primary care doctor didn't feel that he or she was out there waving in the breeze. If there was some integration of the system so that one was really part of the care network as opposed to somebody out there in left field, that would also make it a little bit easier to do what is probably the hardest job in medicine and the least paid, well paid.

Mr. {Sarbanes.} Thank you. That is a great point, and I know Congresswoman Capps and I are very focused on school-based health centers with respect to children, but there is also delivery models you can pursue with respect to seniors, community-based clinics, where do we reimburse, et cetera, that I think can advance the ball so--

Dr. {Avorn.} Absolutely.

Ms. {Capps.} Thank you.

Dr. Burgess for 5 minutes.

Mr. {Burgess.} Thank you, and thank you all really. It has been a fascinating discussion this morning. I have got a number of questions I want to ask. If I interrupt you during your answer, it is not because I am being rude, but I do have

a lot of things I want to get through.

First, Dr. Skinner, I want to talk just a little bit about the accountable health organizations. I spent a fascinating morning in December down at the Center for Health Transformation talking to four of the clinics that have participating in the physician group practice demonstration project where they are talking about things that sound very similar to the accountable care organizations. In fact, one of the things that came up on the discussion was rehospitalizations and giving someone a hospital, I mean, a doctor’s appointment with a primary care physician within 5 days of their discharge from hospital for decompensated congestive heart failure, resulted in an almost disappearance of the rehospitalization. So a very low-cost activity with a very high yield on the other end. So clearly these are areas that it is incumbent upon us to explore.

One of the things that came up, you know, how do we force doctors into these types of practice models, and I am not a big one for forcing, so I put forth another idea, and I would just like to get your thoughts on it.

Medicare, of course, is a federal program. It is not a state program. It runs across the country. If we have groups that conform to all of the parameters set forth for accountable care organizations and granted, this will be

flexible, and this will change over time, but if we have groups that are willing to do that, the doctors within that group, could they, if they were offered protection from liability under the Federal Claims Act like we might do with a federally-qualified health center, it seems to me that is a way to bring doctors into that type of practice. In fact, you might see accountable care organizations set up just to see Medicare patients so that they would be provided that cushion from liability.

Do you think there is, that that is an idea worth exploring?

Mr. {Skinner.} Absolutely. I think that that is a win, win. I think, I don’t like to think about forcing doctors into ACOs, but I think there is also this, that many physicians are concerned about SGR payment cuts, and that is another way to incentivize maybe making it worth physicians’ while to start thinking seriously about whether there is a potential for an ACO in their area as well.

But the more that these organizations grow up, spring up out of existing physician hospital networks the better.

Mr. {Burgess.} Let me go on. Dr. Cassel, I wanted to ask you just a couple of questions. Actually, it relates to some testimony Dr. Skinner gave about the high cost of end-of-life care, the amount of money we spend within the last

few weeks of a person’s life with not really being certain that we are doing much to provide value.

Now, Dr. Smith talked about how we do sometimes do things, and we make ourselves do things that aren’t necessarily a good return on investment. When we did the Medicare Modernization Act, we required that everyone coming into Medicare now have an EKG on their welcome to Medicare physical, even if they have had an EKG just a year or two before for--in conjunction with a surgical procedure.

What if we were to offer, not require, but offer an educational module on advanced directives on that welcome to Medicare physical. We could do it right after the EKG, in fact. The patient is there, putting their clothes back on, and could have this educational module. Sure, pay the doctor, pay the gerontologist for their expertise in proving this education, maybe even incent the patient with some sort of break on the part B premium or some other thing of value that we could return to them.

But what do you think about exploring that as an opportunity for getting more people into thinking about planning for what happens at end-of-life care?

Dr. {Cassel.} That is a very interesting idea, Congressman Burgess, and I think I would like to consider it with you. I think that it is--I could imagine the physicians

not exactly liking that idea for most healthy, you know, let us remember the Medicare age group between 65 and 85--

Mr. {Burgess.} It is the new 40.

Dr. {Cassel.} --most are very healthy.

Mr. {Burgess.} Well, they are getting the Botox.

Dr. {Cassel.} And yeah. They are the ones there for the Botox. That is right. So they might be kind of put off by that, like why are they doing, why are they making me look at this.

Mr. {Burgess.} Again, it is not a requirement but an offer.

Dr. {Cassel.} Right, but an offer, there are very good models of shared decision making, and, again, the group at Dartmouth has been very involved in these and others as well that show that when patients have all of the information and interact with their caregiver around that information, they make, they almost always make more conservative choices about their care.

Mr. {Burgess.} I am going to interrupt you, but I have one last thing I want to get to, and I do want to work with you on that concept

Dr. {Cassel.} So it is a good idea.

Mr. {Burgess.} What about the concept, we had some other testimony earlier in the past couple of weeks regarding

Alzheimer’s Disease, and if you look at the numbers, if people are correct in some of their projections, the numbers are just absolutely staggering from a public health cost. You talked about the gerontologist being out there kind of on their own and sometimes it is a lonely existence.

But with the interconnected world in which we live and we are constructing, what would be the--would there be an opportunity for creating essentially a virtual center of excellence for the long-term management of the Alzheimer’s patient, perhaps even considering some early diagnostics with things perhaps we can do with genomics, the monoclonal antibodies offering some, perhaps some real choices for early treatment.

Is there a place in what we are looking at in the road ahead for developing this type of virtual center of excellence so that the practitioner is not kind of left out there by themselves on this?

Dr. {Cassel.} So this is, this would be a clinical center, not necessarily a basic research center?

Mr. {Burgess.} Well, certainly you could have a physical basic research center, but a lot of practitioners who are in medium-sized communities may have a population of say Alzheimer’s patients within their larger sphere of patients.

If they could link in with other practitioners in a virtual center of excellence, Alzheimer's patients are not likely to require surgery to improve their condition--

Dr. {Cassel.} Yeah.

Mr. {Burgess.} --but the medical management, the long-term management is really so critical.

Dr. {Cassel.} And much of the reason is that geriatricians as Mr. Sarbanes pointed out are not widely available, so you don't even have that expertise, and many physicians don't know what to do, they don't pick up early symptoms of Alzheimer's Disease, and you know, so--and if they do, they are not sure what to do about it.

Mr. {Burgess.} Right.

Dr. {Cassel.} So--and they may prescribe medication unnecessarily, et cetera. So I think it is a wonderful idea. As you may know, I was part of the Alzheimer Study Group with Newt Gingrich and Bob Carrey and Justice O'Connor and others.

Ms. {Capps.} Dr. Cassel.

Dr. {Cassel.} And that was one of our recommendations was that there be resources for community providers.

Mr. {Burgess.} Right.

Ms. {Capps.} Thank you.

Mr. {Burgess.} Let us work on this. Thank you.

Ms. {Capps.} Thank you. And I recognize myself now of

5 minutes.

I will start with you, Dr. Avorn. Because you speak a great deal about comparative effectiveness, and it has been a pretty hot topic around here. I am particularly interested in your comments about translating information into better patient care decisions, and I wondered if you would mind using my piece of legislation, a bill I have introduced, as an example.

It is called the--and it is an acronym, Heart for Women Act, and among other things it would require the FDA to collect and make available information about how drugs and devices work differently in patients of different sex, race, ethnicity, so forth. The goal being that a health professional could determine which drug might be most effective in their particular patient.

Could you explain how this might be helpful for effective, comparative effectiveness research and why it is important that we have a data collection or information like this for quality of care and outcome?

Dr. {Avorn.} Sure. Right now we have a perhaps efficient, perhaps skimpy approach to approving drugs such that if it is better than let us say a dummy pill over a brief period of time in healthy or people that we know will take it in achieving perhaps a lab test change instead of a

clinical change, the drug gets approved. That leaves kind of in the dark patients who may be excluded from those trials. Often they are minorities, often they are women, often they are other vulnerable groups, and the elderly, for example, and the doctor faced with trying to care for those people does not have the information from the clinical trials that we would like to be able to really make a scientifically-based decision for that patient, not the patients who are like the ones in the clinical trial.

And so where comparative effectiveness research would help would be that it would make it possible to fund studies that would zero in on particular at-risk groups. Let us say a group of scientists, physicians, consumers would say, we don’t really know enough about the management of let us say congestive heart failure in blacks or atherosclerosis in women or how Asians metabolize drugs differently. And we would identify on the basis of the medical need for the information, studies that could be done--

Ms. {Capps.} May I interrupt to just--I want to move to another topic as well, but would you kind of locate such a place at FDA or it might even be multi-disciplinary in terms of different--

Dr. {Avorn.} The FDA’s job is to approve new drugs and--

Ms. {Capps.} Right.

Dr. {Avorn.} --we should have--

Ms. {Capps.} Where would you locate this?

Dr. {Avorn.} I would locate this in a trans NIH, AHRQ setting, that is a healthcare research, biomedical research entity that would then be able to make recommendations scientifically.

Ms. {Capps.} I hope we can follow up on this topic.

Dr. {Avorn.} I would be happy to.

Ms. {Capps.} Just opened it up, I know.

I want with the rest of my time to address you, Dr. Cassel, because you spoke a great deal about the importance of coordinating care and the role of the entire clinical team in providing preventative care. That is a very important topic to me.

But so many people talk about a medical home, which is in itself a fairly new phenomenon or label. I would like to propose that we discuss it and talk about it as a health home. When we think of the word, medical, we think of medical doctors and medicine and techniques. Rather I believe we could be talking about the health of the patient as the sort of core, and all of the panoply of health professional involved.

And I wondered if you would sort of give a couple of

ideas of how this might work. I am a nurse, and so I am thinking of the different participants on this team and how that might be coordinated, but I also want to have you close by talking about the structure, how the reimbursement would work in such a model.

I am aware that in oncology there is a whole team already, oncology nurses, who deliver much of the care, for which there really is no designation.

Dr. {Cassel.} Thank you, and first of all, I completely agree with you. I think that the term medical home grew up in this model from pediatrics, which you are probably familiar with, which was where it first began. And it is to my mind unfortunate because particularly from the perspective of a geriatrician, it is all about the team and things like care coordination function I don’t think can actually be done by a solo physician or two physicians in an office with a medical assistant. I actually think--I can’t imagine how they could actually effectively do that unless they outsourced it something like that.

So to my mind you actually need this larger team to qualify for being a medical home. Now, that is not in the Medicare demo legislation. There is a lot of reasons why you want to be able to have those small doctor practices.

Ms. {Capps.} If we--I only have a few seconds. If we

can demonstrate that this is important, how, I mean, it only will work if people get reimbursed.

Dr. {Cassel.} I think there has to be some kind of bundled or global payments rather than--because right now Medicare pays for doctor, and you couldn’t have Medicare pay every different health professional and still have that add all out to everybody being accountable for working as a team. We know this from private industry. If you want to have people work as a team, you pay them as a team, and then you have the team figure out a lot about the reimbursement. So some mixed model that involves some degree of global payment would be my answer.

Ms. {Capps.} Thank you.

Mr. {Shimkus.} Madam Chairwoman, I would like to defer to my colleague, Mr. Shadegg, and then I will take the next one. Thank you.

Mr. {Shadegg.} I thank the gentleman for deferring, and I thank the Madam Chairman.

Dr. Goodman, I would like to begin with you. You spent a lot of time in your prepared testimony discussing with how the system isn’t working well for doctors, patients, employees, employers, people in the non-traditional workplace, insurers, the uninsured, and I tend to agree with you, and I want to kind of explore that. I want to explore--

first of all, I assume the reason that it is not working very well is the structure isn't suited to make it work very well for those people. Is that correct?

Mr. {Goodman.} Yes. It is an institutionalized, bureaucratic, system. It doesn't work like a normal marketplace, and therefore, people don't have the opportunities to improve services and lower costs and raise quality the way they would do in say the market for other professional services.

Mr. {Shadegg.} Indeed, it certainly doesn't operate like a normal marketplace, because in this marketplace the consumer of the good doesn't buy the good. That is kind of bizarre, isn't it? I mean, I am the consumer of my healthcare, I am the guy that goes and sees my doctor, I did over the Christmas break, went and saw a doctor, but I didn't hire that doctor, and I didn't hire the plan that hired that doctor. I just signed up to work here at the Congress. Is that a part of the distortion of this marketplace, and is there even a marketplace in healthcare?

Mr. {Goodman.} Well, that is the fundamental cause of the distortion. As I said earlier in my testimony, it is also the fundamental cause of the distortion of the education market, which has many of the same problems. The entity that benefits is not the entity that pays the bill. There are, if

I can just say, there are emerging healthcare markets where third parties aren't involved; cosmetic surgery, lasik surgery, the walk-in clinics, the concierge's doctors. All of those areas are where the market is working well. You have price transparency, you have price and quality competition.

So if we contrast those two markets, you can see radial differences.

Mr. {Shadegg.} I would argue the problem we have in the current healthcare market for most Americans is that it is all controlled by third parties. I am a ploy or one just kind of pawn being moved around, and my doctor is one also, and the whole thing is being controlled by my employer, who doesn't really care too much about, you know, he would like me or she would like me to have a good healthcare but that is about it. And then by the plan that my employer buys.

I sent my staff an e-mail a little while back where I said, okay. Let us assume that going to work in Congressman Shadegg's office meant that Congressman Shadegg was going to provide you free lunch every day. And I supposed that for one of my employees I would go buy him a ham sandwich every day, and for another one I would go buy them a salad. The problem is that the employee that I bought the ham sandwich for actually hates ham, and the employee for whom I bought

the salad can’t stand salads.

That is kind of the way the market, the so-called healthcare market works, isn’t it?

Mr. {Goodman.} Well, that is why I entitled those sections free the doctor, free, the patient, but also free the employer. He is not happy with this either.

Mr. {Shadegg.} He is not happy with it. We have a situation--I think the problem in healthcare in America today really comes down to two things. The uninsured, and I think we need to cover them all, every single one, and I have drafted a bill to do that, and cost, and costs are spinning out of control.

I kind of drew this up. Here are the costs of inflation in our society, and here are the costs of healthcare or health insurance. Health insurance is rising exponentially faster or health costs or rising exponentially faster than any other area. Right?

Mr. {Goodman.} Twice as fast as income growth. And by the way, it is not just the U.S. problem. That is happening all over the developed world.

Mr. {Shadegg.} Including places, other places where they have divorced the consumer from--

Mr. {Goodman.} Everywhere all over the--

Mr. {Shadegg.} I just have a question for you. In auto

insurance I happen to note that I can’t go home one evening and watch TV and not see two, three, four, five auto insurance commercials where the little gecko comes on and says he wants my business or the State Farm guy comes on and says he wants my business. But I note that I never see a commercial like that from United Healthcare or any of the healthcare companies.

Is that related to this problem?

Mr. {Goodman.} Well, I do see some insurance commercials, but these are commercials for buying insurance in the individual market. They are not commercials for group insurance.

Mr. {Shadegg.} And what percentage of the American people get their healthcare in the individual market?

Mr. {Goodman.} Well, less than 10 percent.

Mr. {Shadegg.} And what does the government tax policy do to those people?

Mr. {Goodman.} It discriminates against them. If you are self-employed, you get to deduct your premium, but you don’t get relief from the payroll tax, and if you are just off on your own, you get virtually no tax relief.

Mr. {Shadegg.} You get smacked. You get smacked right in the face. You get told, well, you can buy health insurance, and we think you should because we really don’t

want you to show up at the emergency room where you can get free care, but since we have told you we want you to go get health insurance, we are only going to charge you one-third more for it, roughly one-third more for it, because you got to buy it with after-tax dollars. Right?

Mr. {Goodman.} Yes. The uninsured who happen into an emergency room more often than not get charged more than any other payer in the emergency room.

Mr. {Shadegg.} How well does a system of that type and the fact we have now where you have divorced the payer from the consumer, and you put these people in-between them, how much would that be helped by substituting the government for where the employer and the insurer or the plan is right now? Instead of having the plan, how much by contrast would it be helped if we made a direct connection between consumers and providers, hospitals or doctors, by allowing people to have the money they need to buy the plan that suited their need?

Mr. {Goodman.} Well, not very much help by the government, because in my opinion the private insurances is almost as bad as government insurance. Half the people in the country are on a government plan and--

Mr. {Shadegg.} Fifty-seven percent I hear.

Mr. {Goodman.} --the private plans pay the same way the government plans pay. So there is really not all that much

difference. The markets where you really see a lot of difference are the emerging markets where there are no third-party payers at all, and those are working remarkably well.

Mr. {Shadegg.} Kind of like auto insurance where people can buy directly from the auto insurer and get their car repaired.

Mr. {Goodman.} Yeah, but I was thinking of markets where people pay directly for care.

Mr. {Shadegg.} Good enough for me. Thank you very much. My time has expired.

Ms. {Capps.} Mr. Shimkus for 5 minutes, please.

Mr. {Shimkus.} Thank you.

Dr. Avorn and I am not sure who else talked, and I can get very deeply in this, but I am concerned about this cost-effectiveness issue, and it was raised earlier. What in a cost-effectiveness ratio fighting aggressive cancer for 10 months or allowing the person to die because they have aggressive cancer in 2 weeks? If that was scored out budgetarily, what would cost more?

Dr. {Avorn.} First I think it is important to distinguish between collecting the information about what works and what is safe for patients and what is a good buy, on the one hand, versus coverage decisions which are really quite separate so that one can imagine collecting the data

about which treatments are the safest and the most effective versus their price. That is separate from what Medicare or Medicaid or a private insurer may choose.

Mr. {Shimkus.} Well, let me tell you why I mention this, and because I was, you know, I, like everybody does, we meet with folks, we may have personal relationships of things that are going in everybody lives like this. I talked about my concern of a rationed care system developing under cost. I was, again, at a student forum, and one of the students popped up and said, you know, well, it doesn’t make sense to fight aggressive cancer for 10 months. The cost benefit analysis doesn’t score out.

So for us to say that that is not part of a debate which I think eventually we move to--if we don’t keep private insurance as a very important option in this country, if we move to a public option which destroys the private insurance, you know, provision and then we go to a one-payer system, that is my concern; a rationed care system which will decide when you get care based upon budgetary aspects. And that is why those of us who are--comparative analysis, cost effectiveness, that is where our concern comes from, and I just wanted to throw that out to talk about that.

And let us just kind of segue, and this will be--I think the chairman submitted this for the record, the New York

Times article. Is that correct? On--so my question is going to be related to the Medicare and really segue into Medicaid. One of the provisions that is being discussed here is Medicare for all. And now if you believe this article, doctors are opting out of Medicare, and if you go around your Congressional districts and talk to physicians, this is what we know is occurring. With this growing access to care issues, if we add millions of people to the Medicare system, a Medicare for all, does that help or hurt this problem of doctors fleeing?

Anyone want to comment? Dr. Goodman.

Mr. {Goodman.} It hurts it. What is happen now is Medicare is paying below market, let us say 30 percent below market, but not everybody can get below market. If you are a doctor, the first patients you want to see at the beginning of the day are the ones who pay market, and Medicare would be next, and Medicaid, which pays below Medicare, would be at the end of the line.

If you try to put everybody into a system that is underpaying, then you exacerbate the supply side, and yes, it will make the rationing problems worse, and rationing by waiting is not access to care.

Mr. {Shimkus.} Anyone else want to comment? Mr. Smith.

Mr. {Smith.} Yes, and in my opening remarks I did

suggest that people look at the experience of Medicaid over the past several years which resorts at the end of the day very much to price controls, to where you have access, real access problems for the Medicaid population. One-third of all Medicare ambulatory visits are to the emergency room to an outpatient hospital facility.

So this is where a single payer system ultimately drives you to because you have now overburdened the system. As we have seen in the states, then the reaction to that is to squeeze back against the providers to try to lower the cost that way.

Mr. {Shimkus.} I am sure, did the Medicaid question get asked? Does anyone want to swap their current insurance policy for Medicaid? Did that get asked of the panel? Can we go through Dr. Skinner all the way down? Who would--let us start with Dr. Skinner, and I will end with that question. Would any of you opt out to go to Medicaid over the insurance product that you currently have? You don’t need to direct him, Dr. Cassel. Let Dr. Skinner ask--answer.

Mr. {Skinner.} I happen to have a pretty good plan, so I was not--

Mr. {Shimkus.} So you would not accept Medicaid as an alternative.

Mr. {Skinner.} Everybody is so fortunate.

Mr. {Shimkus.} Dr. Cassel.

Dr. {Cassel.} I am not sure why, what is the background of that question.

Mr. {Shimkus.} The question is the debate of if we have uninsured and we provide them access to Medicaid--

Dr. {Cassel.} Uh-huh.

Mr. {Shimkus.} --as an option. Would you personally be willing to give up your current insurance product for a Medicaid--the question is is that a good deal?

Dr. {Cassel.} Well--

Mr. {Shimkus.} But the real question I am posing is with the insurance--

Dr. {Cassel.} Right.

Mr. {Shimkus.} --that you personally have, would you trade that if offered Medicaid in a trade?

Dr. {Cassel.} No. If I were uninsured--

Mr. {Shimkus.} Okay. Thank you.

Dr. {Cassel.} --you bet I would.

Mr. {Shimkus.} Dr. Goodman.

Ms. {Capps.} I don’t think we are going to make it through the end of the line.

Mr. {Shimkus.} Well, I think we will. If they would answer the question.

Mr. {Goodman.} Of course not and I wouldn’t try to--

Mr. {Shimkus.} Thank you.

Dr. {Sigsbee.} I am going to be distinctly different. I would. In my area--

Mr. {Shimkus.} We had one last week that said they would.

Dr. {Sigsbee.} And Medicaid pays for all medications. You don’t have to have anything out of pocket, so that I would actually. From a provider standpoint, though, Medicaid pays below the cost of providing the service. So it would be--

Mr. {Shimkus.} You might have some access issues then with doctors not wanting to--

Dr. {Sigsbee.} Right. You would have some serious access problems, and it would be unsustainable to be in medical practice.

Mr. {Shimkus.} Mr. Smith.

Mr. {Smith.} No. In Medicaid there are 56t different Medicaid programs, and in due respect to my colleague here, I mean, there are states that say you can have four prescriptions a month. So you don’t have unlimited access to prescription drugs.

Mr. {Shimkus.} Dr. Avorn.

Dr. {Avorn.} There are 47 million Americans who would say absolutely yes.

Mr. {Shimkus.} No. The question is you.

Dr. {Avorn.} Well, I happen to be an affluent American who has good--

Mr. {Shimkus.} So your answer is?

Dr. {Avorn.} I would not want--

Mr. {Shimkus.} Thank you very much.

Ms. {Capps.} And now it is time to say thank you very much. Your--the panelists have been amazing in your forbearance of all the questions, but also your testimony is valuable as we go about making some very important decisions in Congress affecting healthcare. Thank you very much.

We will excuse you and give you a break and ask for our second panel to take places at the table.

In the interest of time we have three of our four panelists, and one will be here shortly. I will introduce the three and then we will ask you to begin, Dr. Ginsburg, and I will introduce Mr. Bachman when he arrives.

We are pleased that you are here with us this afternoon. Paul Ginsburg, President of the Center for Studying Health System Change, to be followed by Dr. Regina Herzlinger, Professor of Business Administration at Harvard Business School. I will jump over to Diane Archer, Director of the Health Care Project, Institute for America’s Future.

And Dr. Ginsburg, you may begin your 5 minutes of

2528 testimony.

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^STATEMENTS OF PAUL GINSBURG, PH.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE; REGINA HERZLINGER, PH.D., PROFESSOR OF BUSINESS ADMINISTRATION, HARVARD BUSINESS SCHOOL; RONALD BACHMAN, F.S.A., M.A.A.A., SENIOR FELLOW, CENTER FOR HEALTH TRANSFORMATION; AND DIANE ARCHER, J.D., DIRECTOR, HEALTH CARE PROJECT, INSTITUTE FOR AMERICA'S FUTURE

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^STATEMENT OF PAUL GINSBURG

} Mr. {Ginsburg.} Thank you, Madam Chairman, Mr. Deal, and members of the subcommittee.

Ms. {Capps.} You might want to turn on your microphone and pull it a little--there.

Mr. {Ginsburg.} Appreciate the invitation to testify on price and quality transparency of healthcare services.

In theory, more information on provider prices and quality can lead to lower prices and higher quality. Those consumers who choose differently will benefit, and if enough people make different choices, providers will be motivated to reduce their prices and increase their quality, extending the benefits beyond those acting on the information.

But today the reality does not line up well with the theory. Few consumers use such information to make choices.

The tools to measure and communicate price and quality information are primitive at this point, and most consumers are not incentivized to consider price and not aware of the variation in quality among providers.

Focusing first on price transparency, the key factor limiting the potential impact today is the lack of incentives in today's insurance benefit designs. There is little reward for choosing lower-priced providers, and this is even a problem in high-deductible plans with savings accounts. Much of the information that is available to consumers is not in forms that they can use. Hospital care is not priced in units that are meaningful to patients such as per stay or per episode. Some information now provides ranges per episode, which is progress.

The same issue with physicians. Fee levels do not provide insight into what services will be provided, and information that state governments and the Federal Government has provided are not reflective of people's health insurance. Also, there is a legitimate unwillingness by consumers to choose providers on the basis of price when they have little, if any, information on provider quality.

There are some risks of unintended consequences of additional price information. For one, if the information discloses contracts between hospitals and insurers, this

risks driving up prices. This is an accepted perspective and anti-trust policy throughout the world that when markets are highly concentrated, disclosure often leads to higher prices.

And another unintended consequence is that some consumers, particularly those who don’t have incentives to look for lower prices, will use price as an indicator of quality and go to the higher-priced providers.

There are opportunities to do better. If we reform provider payments, this would create much more meaningful prices for consumers to respond to. Now, insurer high-performance networks can be seen as a first step in this direction, although success has been limited by the use of different measures by difference insurers and lack of engagement of physician leaders. Information on charges by out-of-network providers and on what insurers pay for these services can be helpful. There are large differences in what patient pays between in-network and out-of-network providers, and the database to be developed in the State of New York will support an important increase in transparency about out-of-network care.

Now, quality transparency is much more challenging than price transparency. The measurement is very complex. Much of the measurement of quality these days is based on processes rather than outcomes because of such limited data

on outcomes, and processed measures of quality are inevitably going to be limited by our lack of knowledge about effectiveness. We need to know what processes really do improve outcomes.

Providers are a key audience for quality information so that even if consumers don't use it, there is a lot of potential with providers. They are highly responsive to quality measurements, and they take steps to improve quality even if there is no pressure from consumers. And the example that Dr. Sigsbee on the first panel mentioned in his practice is a great example of the phenomenon.

There are important roles for governments in advancing quality transparency in addition to the reporting that governments are doing now. They can convene provider leaders and insurants who agree on common measurements. This would enhance the credibility of measures to providers and also avoid excessive burden on providers from multiple reporting requirements.

Sponsoring effectiveness research to strengthen, will strengthen the ability to assess quality, and there is potential for the private sector to analyze and communication the public data such as trusted not-for-profit organizations like consumers' union or commercial data vendors like Web MD.

In conclusion, transparency has the potential to

increase the value from our underperforming healthcare system, but benefits are probably very small now, but there is potential to increase in the future. But we could lose in pursuing transparency by overselling its potential and deluding ourselves that other steps to increase the value in healthcare are not needed.

Thank you very much.

[The prepared statement of Mr. Ginsburg follows:]

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Ms. {Capps.} Thank you.

And now we turn to Regina, Dr. Herzlinger.

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^STATEMENT OF REGINA HERZLINGER

} Ms. {Herzlinger.} Thanks so much, Madam Chairwoman, Ranking Member.

Ms. {Capps.} Is your microphone on?

Ms. {Herzlinger.} Thanks so much, Madam Chairwoman, Ranking Member Deal. I am used to screaming in a classroom, so I thought I was all right. I am honored to be here.

What does healthcare reform mean? Sure, most people want to buy reasonably-priced health insurance policies, especially if they are threatened with unemployment as sadly we are in this economy, but many people don’t want government to control the process. So I think there is going to be a lot of wrangling as these two opposite points of view get sorted out.

But there is a healthcare reform that can be much more readily implemented, and that is transparency. Everybody wants the government to help them make buying decisions by providing good information. They like FCC data about corporate financial performance, EPA data about cars’ pollution, and USDA and FDA data about whether our chuck roast is prime or choice grade and the cleanliness of the supermarket.

Expert clear communicators help consumers interpret these sometimes arcane data ranging from consumer reports for cars to media business gurus for stocks. When it comes to our troubled healthcare sector, Americans want government to provide information, too. Why do we know more about the quality and prices of our chuck roasts and supermarkets than about our surgeons and the hospitals in which they practice? Americans do not want the government to use these data to evaluate the cost effectiveness of products or to buy on their behalf.

Franklin Delano Roosevelt, the great president, understood the distinction between government-enabling information and government making decisions on our behalf when he opted for transparency to cure the stock market's collapse during the depression. FDR was advised by his counselors that the government evaluate all securities. He rejected that advice. Instead he created the Securities and Exchange Commission. He called it to the Truth Agency. It was going to tell the truth about the corporate sector to require corporations to disclose their results using that which were audited by independent, certified public accountants.

The FCC armed the--was armed with hefty enforcement power. The FCC has been a miserable failure in its

regulatory function, but extensive academic research demonstrates how successful its truth-telling mission has been. Transparency has lowered the cost of capital because when investors are uncertain about performance, they require high returns. Transparency helps protect against misappropriation of shareholder returns by managers. You see it right now with the current outcry against CEO compensation. Most importantly, it enabled appropriate allocation of our resources. Investors reward productive, socially-responsive firms more than others.

In contrast, we know virtually nothing about the quality and cost of medical providers or about the performance of our hospitals and our insurance. Transparency would enable a woman who is contemplating a mastectomy to know the death and disability rates of potential surgeons, infections, clots, medical errors like leaving a sponge, rates of readmission, infection rates, and the prices they charge for similar kinds of patients.

Transparency would also enable consumers to better evaluate their insurance firms through information, for example, about the number and types of complaints the firms receive from irate customers or medical care providers and their responsiveness to them.

This kind of transparency will enable properly-informed

consumers to reform healthcare by selecting the providers and insurers that give them the best value for the money. Some contend that transparency leads to price collusion. If this were true, every yogurt on your supermarket shelf would bear the same price. It doesn't, because the yogurt industry is highly competitive. Collusion is possible only in the highly-concentrated allagopolistic markets. Transparency facilitates the government's prosecuting price fixing competitors in these industries.

You are all too young to remember the NASDAQ scandal where dealers rounded up to the nearest eighth of a penny. The reason that we know about that scandal is that information was transparent and academic researchers found the collusion that led to a $1 billion payout by the colluding allagopolistic securities firms.

Voluntary disclosure dose not work. How do I know that? We have no information. As demonstrated elsewhere in our economy transparency through a truth agency will go a long way to reforming healthcare. Representative Deal's bill captures the essence of what this kind of health reform is all about.

Thank you.

[The prepared statement of Ms. Herzlinger follows:]

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Ms. {Capps.} Thank you very much, and I would like to welcome to the panel Mr. Bachman, Ronald Bachman, Senior Fellow at the Center for Health Transformation. You are recognized for 5 minutes.

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^STATEMENT OF RONALD BACHMAN

} Mr. {Bachman.} Thank you. Ron Bachman, Senior Fellow at the Center for Health Transformation, and my mission in life is to solve the uninsured problem, and so the transparency issue before us today is very much a part of that in my opinion.

Transparency means the public disclosure of honest, meaningful decision making information. Clearly the public has a right to know key information to maintain their health and safety. When up to 98,000 patients die each year from hospital errors, citizens have a right to know where these are occurring. When 9,000 deaths occur from medication errors each year, the public has a right to know the facts. When hospital-created complications and provider-induced viruses are more deadly than the original medical conditions, patients have a right to know.

The best way for the public to change poor business behaviors is to improve--and to improve quality and lower costs is for the guilty businesses to lose customers. Unfortunately, in healthcare the consumer is rarely the customer. The consumer is the one who uses the service. The customer is the one who buys the service and pays the

invoice. In healthcare the customer is usually the third-party payer, the insurance company, the HMO, or the group plan.

New generation health plans are financially empowering health consumers and transforming them into health customers. To become an effective health customer, one has to have both a financial stake in purchasing and the information to make informed decisions. You cannot have a quality healthcare in any system without both.

Financially-empowering plans with savings options increase 5 percent in 2007, and 8 percent in 2008. Employers with three to 200 workers are the fastest growing group, up 13 percent. With account-based plans individual worker premiums are 40 percent less than other plans. Family premiums are 30 percent lower. The average employer account funding was over $800 for an individual and over $1,500 for family coverage each year. In 2008, 71 percent of employers offered incentives for health and wellness or disease management programs up from 62 percent in 2007. The incentives averaged $192 per person per year.

Account-based plans are not just for the healthy and wealthy. In 2009, young families, 25 to 40, had balances averaging over $7,000 in these accounts. By the end of 2008, the average savings accounts total over $8,000 for

individuals and over $10,000 for families. The newest products are developing more information to help individuals make informed choices with those dollars.

Historically transparent cost and quality information has been hard for plans and the public to access. Providers have maintained the argument of confidentiality, proprietary needs, and competitive advantage. With empowered individuals these arguments rapidly dissipate. National insurers, some providers, especially vendors and state governments, have been taking the lead in requiring disclosure of provider cost and quality information. Each insurer or hospital has limited data. States differ on the reporting requirements. Budgets limit the expansion of publicly-funded information access, and inertia of the status quo slows progress in meeting patient information needs.

The Federal Government can advance the cause of empowering individuals with the information by passing basic national standards for provider and insurer transparency. Congressman Nathan Deal’s legislation is on the right path.

A governor of Georgia once said that that to have better prisons we needed better prisoners. Today that parallel may be to have better health and lower costs we need better patients. The CDC tells us that behaviors determine 50 percent of health. By far the individual turns out to be the

most important variable in the healthcare cost equation. It is not doctors, hospitals, pharmaceuticals, or other care providers. Access to care has only a 10 percent impact on health status, genetics, 20 percent, environment, 20 percent make up the remaining factors.

Congress is a powerful legislative body, but you cannot change the laws of human nature. You cannot make recalcitrant patients take medications or comply with physician orders. You cannot make citizens each properly, exercise regularly, or seek preventative care. The bottom line is you cannot legislate personal responsibility.

Congress can, however, create an open, transparent information-rich environment that supports greater engagement by individuals in their own health and healthcare decisions. In general, individuals will not take care of themselves just for the sake of good health. If that were true, we would not see the rampant growth in obesity and epidemic of diabetes. We are typically American. We want to paid to do the right thing. We want incentives, rewards, and recognition. We want some financial control, and we need information and help with making the right decisions.

Blue Cross, Blue Shield studies show that patients with financial and information support have more than three times the number of members engaged in smoking cessation, more than

three times the number of members engaged in stress management programs, more than double the number in diet nutrition education programs, and nearly two and a half times more likely for those patients to be in exercise plans.

A major interest in Congressman Deal's legislation is the disclosure of self-pay charges. When I started to negotiate provider network reimbursements back in the early 1990s, the expected discount from hospital charge masters, their so-called retail price, was typically 5 to 15 percent. The discount game had led to artificially-high retail price lists where discounts are now 80 to 90 percent off of those charges. No one pays the retail prices except the uninsured. Those most vulnerable and least able to pay are charged the list rates. Many who cannot or do not pay these artificial charges are hounded by collection agencies for monies that are ten times or more above the cost of actually providing the services.

As with the Georgia governor's call for better prisoners, it is time to free consumers from the dark prison of ignorance. You can make information easier to find and easier to understand. You can eliminate arbitrary price discrimination against the uninsured. The need is to pull back the curtain of secrecy on costs and quality. Congress can make a difference in saving lives and saving money by

supporting the individual’s right to know.

While the country debates reform of healthcare, on one fact you should all agree. The need for transparency is critical to the outcome in that debate.

[The prepared statement of Mr. Bachman follows:]

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Ms. {Capps.} Thank you, Mr. Bachman.

And now we turn to Diane Archer for 5 minutes, please.

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^STATEMENT OF DIANE ARCHER

} Ms. {Archer.} Madam Chairwoman, Mr. Deal, thank you for inviting me to testify about transparency in the private health insurance system and how it can help American families.

At the Institute for America's Future we studied the issue extensively and concluded that the private healthcare system will never work well for American families without significant changes in the current disclosure practices with the private insurance industry.

Here is why. If you wanted to buy a car, you would have a vast array of public information about differences among them, from fuel efficiency to annual maintenance costs to crash test performance. But what can you find out about the various makes and models of private health plans? Practically nothing it turns out.

So what is the value of having so many choices? Even the most sophisticated among us have little idea what we are paying for when we buy insurance. Does it cover Tamoxifen if I am at risk for breast cancer? How much is the average out-of-pocket cost for typical prenatal care? What percentage of total claims were denied last year? What will a particular

service cost me?

Private insurers in sharp contrast the public Medicare Plan have been able to keep confidential claims, costs, and quality data on the ground they are business trade secrets. We can’t find out what specific services will be covered and when or average out-of-pocket costs for typical conditions, let alone which insurers deliver the best value for our premium dollars.

Informed consumer choice is a myth. To build an efficient healthcare system we need insurance company performance information. I have spent the last 20 years helping people navigate both Medicare and private insurance, for a long time as president of the Medicare Rights Center. I want to take you briefly through the structural issues that may preclude needed transparency from the private insurance industry, the data was need from private insurers, and how healthcare reform can address these issues.

In America today people can’t compare health plans based on value. The health insurance market is broken. In a competitive market insurers would be marketing to healthcare users, demonstrating why they deliver the best value healthcare for people with cancer, diabetes, and heart disease. Their message would appeal to the 20 percent of the population who consume 80 percent of healthcare dollars.

Instead, if they deliver great care to people with costly needs, they don’t want people to know. Twelve years ago in a New York Times magazine cover story that I keep by my side, Helen Darling, now president of the National Business Group on Health, made this point very succinctly. ``I have been sworn to secrecy by one plan that has the best AIDS program in the world. They don’t want people knowing about it. They couldn’t handle the results. Ideally, if we lived in a wonderful world, we would want to plan to win prizes for their wonderful care, but in reality that would kill them.'' To maximize their profits health plans compete for enrollees least likely to use their product. Therefore, health plans do not advertise to specific treatments and tests covered but conditions under which they are covered or the crisis services.

This is precisely the information we need to know. Different private plans offer different value healthcare. The best of them help ensure doctors deliver good care, yet coverage decisions are largely considered proprietary and unknown. And we don’t know whether insurers are adding value or simply increasing their profits.

A New York State Medical Society survey revealed that 90 percent of doctors said they have had to change the way they treat patients based on restrictions from an insurance

company, and 92 percent said insurance company incentives and disincentives regarding treatment protocols, ``may not be in the best interest of patients.'' Are insurers spending our premium dollars wisely? Are they helping to ensure that our doctors provide us reasonable and necessary care? We don’t know.

What data is needed to evaluate health plans and help people make informed healthcare choices? The kind of data we get from the public Medicare Plan, the specific services they cover, and the amounts they pay, claims data and denial rates. Members and perspective members also need to know the average out-of-pocket costs for treating different conditions. This data will help give us meaningful choice, and over time will help us in efforts to compare health outcomes for people with different conditions in different health plans.

As important, disclosure of this data would promote better insurer behavior. Right now the countless reports of insurer abuses suggest that the lack of transparency allows insurers to delay and deny care and reimburse inadequately for services renders, seemingly arbitrarily.

Up until now we have bought into an opaque and inefficient private health insurance model that has not met our healthcare needs. Regulations will never address the

insurer’s obligation to put profits first, but we can drive accountability if we require far greater transparency from the insurers.

A public health insurance option is also essential. A public health insurance option sets a benchmark for coverage, drives competition among insurers to reign in costs, and through its willingness and ability to be transparent and accountable can promote the value and system-wide change that is needed to guarantee everyone in America quality, affordable healthcare.

Thank you.

[The prepared statement of Ms. Archer follows:]

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Ms. {Capps.} Thank you, and now we--and I thank each of you for this interesting panel.

Mr. Deal, why don’t you begin with your 5 minutes of questioning.

Mr. {Deal.} Thank you, and thank you to all of you for waiting this long to be here for this. Obviously, as you know, transparency is an issue that is of importance to me.

You know, almost every other thing in life we know what the cost of it is. Healthcare we don’t know. We don’t know the results. We don’t know what the effectiveness is of hospitals or of individual practitioners within the medical community. So transparency on all of those fronts I think is an important ingredient.

For those who would say that just because people don’t pay for things out of their pocket that doesn’t mean that--it means that they are not concerned about the cost, I would like for them to have been in conversations where family members, when they have a relative who has been transported to the hospital, the one thing that they always complain about is the $700 ambulance fee charged to transport their loved one for less than a mile. Now, you can believe they focus in on those kind of things, and they want to know why public programs are paying what they consider to be

exorbitant prices. The trouble is they don’t know those kind of things in their healthcare in general.

So I appreciate the testimony that we have received.

I think, Mr. Bachman, you almost sounded like I wrote your speech for you there. I think I agreed with virtually everything that you said. How do we deal, though, with this question of disclosure of pricing, price transparency? How do we get a handle on that? How do we best accomplish that objective?

Mr. {Bachman.} Well, there are a number of areas. First, I would like to say that the transparency that I believe is appropriate goes beyond even what has been suggested in your bill here. I think transparency on service costs, how well you are being treated, the time in the waiting room, bedside manner, things that are not clinical but are more service oriented is important disclosure.

The way we get at it is a couple of things. One of the issues that was not mentioned in the earlier panel, I didn’t mention it, and I hadn’t heard the words here is the internet. We are now seeing a tremendous growth in what is called web2.o, people talking to other people about their experiences with providers and physicians. So we are having people talking to other people that is creating a disclosure. That is one thing.

The second thing is the growing interest, it is slow, but there are vendors out there that are beginning to encourage providers to create package pricing so that you have one price. How much is it going to cost to treat my diabetes for the next 12 months? And that way if there is a package pricing, it is sort of a combination of the old capitation rates and fee for service mainly, but it is where the provider says I can take care of you for this amount of money, and the services don’t have to fall into the traditional CPT codes or ICD9 or DRGs. It is what the hospital can show and demonstrate will work best, and employers are buying into that. But that is only at the beginning stages.

The third area that is going to push that is that is what is actually happening. I think your chart showed a third-world country. Well, that is actually happening today in most of the areas like Singapore and other countries that are getting medical travel and medical tourism, if you will, and hundreds of thousands of people are going across the ocean in order to get services that are one-tenth the cost at better hospitals, more modern hospitals, many of them managed by the major brand-name facilities in this country, and they are being treated by doctors that are trained in the United States as well. So--and they are being approved by quality

organizations that approve quality hospitals in the United States as well.

So I think there is a gathering of a number of forces to push this in the right direction.

Mr. {Deal.} Dr. Herzlinger, we heard Dr. Ginsburg talk about pricing on a per-episode basis, and I think we are hearing a lot of talk about how do we refigure compensation for services and episode-based, you called it package pricing. I presume it is sort of the same concept.

Dr. Herzlinger, how as we, I think we will certainly look at that issue very closely because it appears to be coming from a variety of sources, how do we make that kind of pricing information available, not just the fact that the services are being bundled but the costs associated with that bundling?

Ms. {Herzlinger.} If you are asking about the administrative model--

Mr. {Deal.} Yes. You suggested something similar to the FCC, I think.

Ms. {Herzlinger.} Yes. Well, the most transparent market in the world is the financial market, and it has led to what is called deficiency in the markets. It doesn’t mean that it is perfect. We know it is not perfect, but it is the most transparent market. There are countries all over the

world that are adopting the FCC model, and the reason they are adopting it for their own financial markets is that that model creates the best transparency.

The FCC model has two parts. One is the Iron Fist. That is the FCC. The FCC has tremendous enforcement power. The Velvet Glove is an organization that is now called the FASBE, and that is a group of stakeholders. They are experts in measurements, accountants, people from the business community, CFOs of companies, and consumers. And then Velvet Glove is the one that actually determines what should be measured.

Companies have to comply with these standards. If they don’t, the Iron Fist, the FCC, comes along. It has been a fantastic model that countries all over the world emulate. We should use it for healthcare. It works.

Mr. {Deal.} Madam Chairman, I know my time is out, but I would ask unanimous consent to include a letter from the executive branch of the State of South Carolina supporting the concept of transparency.

Ms. {Capps.} Without objection, so ordered.

[The information follows:]

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Ms. {Capps.} And now I allow myself 5 minutes to ask my questions, too, and as you may have noticed, the buzzer rang, and we do have votes on the Floor at the same time. We can wrap this up, but we won't be able to go to a second round, which is unfortunate.

Dr. Ginsberg, you testified that one of the key barriers to making price transparency work is the lack of transparency on quality of care. It is clear that hospitals' prices may be low because they are understaffed or they use cheap medical devices and so on and so forth. As you have pointed out, consumers may assume that high-priced providers are high-quality providers, an assumption that may have no basis in fact.

So where do we stand, this is a large question for a short amount of time, in producing information on provider quality that could be accurate and usable by consumers. If we require quality transparency tomorrow, would there be any standard? Would there be information available, and what should we be doing now or taking some steps in this direction as we seek to reform healthcare?

Mr. {Ginsburg.} Well, in the case of hospitals we do have some--

Ms. {Capps.} You may turn on your--

Mr. {Ginsburg.} Yeah. I think it is on. In the case of--

Ms. {Capps.} Okay.

Mr. {Ginsburg.} --hospitals we do have some quality data. I think a lot has been accomplished when the Medicare Program offered an incentive to hospitals. If you would report on these measures, we will pay you a little bit more. Virtually all the hospitals have done this.

I don’t think consumers are making much use of it now. It is pretty fragmented, but when it comes to the hospitals themselves, everything that they are reporting to Medicare or to the Joint Commission they are focusing on improving. An example we had on the first panel about when physicians and hospital leaders see low quality in their practice, they are very motivated to do something with it.

So I think in the next few years we can get a lot of mileage out of quality reporting and transparency just from the provider reaction to it, even if consumers using it I think is many years down the road.

And as far as price transparency, I don’t have, you know, problems with it in general. I think there is potential for it definitely down the road, and my main caution was that we shouldn’t get too wound up in how much it will accomplish in the short run. There are a lot of other

things that have to be done to improve our healthcare system.

Ms. {Capps.} Thank you. I know there is more follow up because I am also interested in how consumers can benefit by this as they make their decisions and out into the community settings, clinics and so forth, which is where a lot of decisions get made.

But I want to turn because there are just a couple of minutes left to you, Ms. Archer. You--a key feature that consumers are interested in for most products is the warranty or guarantee. They want to know if something goes wrong there is a way to get the problem resolved. In the health insurance market, we have heard story after story about denial of claims, some very egregious appeals rights in place on paper but really not very effective.

The problem is consumers don’t even know about their rights before they purchase health insurance. Can you describe what information about appeals and grievance procedures would, should be there, available to consumers in language they could understand? And do you think that more transparency on appeals and grievance procedures will be--is the way we should go in terms of ensuring that consumers, that insurers will do the right thing?

Ms. {Archer.} Yeah. Thank you for that question. Actually, we have a big lesson to learn from Medicare on this

front. The way Medicare works, its data about what it covers, and under what circumstances are all on the web, and if a doctor performs a procedure that is medically unreasonable or unnecessary and delivers it, it is the doctor who actually gets stuck holding the bill, because the doctor can go online and find out in advance what is covered.

If the doctor thinks it is really necessary, the doctor can tell the patient, yes, I think you should have it, but Medicare won’t pay for it and have the patient sign in writing that he or she is willing to pay privately. If Medicare doesn’t pay, the patient can then appeal and has gotten a written notice about it.

So the patient isn’t stuck with a lot of bills from insurer denials that often patients in the private insurance marketplace face because no one knows, including the doctor in many instances, ahead of time whether the insurer is going to cover the claim or not.

So I think that model is a model that could easily be adopted to the under 65 population to help patients in terms of protections financially. If a service a doctor wants to give on this--

Ms. {Capps.} Could this be accepted by the private sector?

Ms. {Archer.} It should be accepted by the private

sector, because it is the fairest way to protect the patient from receiving medically-unreasonable and unnecessary care from a doctor. Why should the patient receive the service if it really is unnecessary? Everybody is on notice that is what the insurer thinks. If the insurer is wrong, if the outside world says the insurer is wrong, the insurer is going to come under attack, under public scrutiny, and will have to change its practices. If it is appropriate and what the doctor is doing is inappropriate, then the patient shouldn't be absorbing the cost of the care.

Ms. {Capps.} I wish I had time to ask others what you think, but you believe, Ms. Archer, that Medicare does provide at least some kind of model for doing this.

Ms. {Archer.} An excellent model. And then I think, just to your second question, I think the denial and grievance information needs to be public so that, again, it can be scrutinized and people can understand what insurers are doing.

Ms. {Capps.} Thank you again very much all of you. This is abrupt because of our call to the Floor, and I appreciate very much your testimony. The reason the microphone is needed is that this is part of our record now, and we appreciate that as I state, we go about making some important decisions.

[Whereupon, at 2:30 p.m., the subcommittee was adjourned.]